ASSESS THE PSYCHOLOGICAL AND SOCIAL IMPACTS OF EPILEPSY AMONG EPILEPTIC CLIENTS ATTENDING NEURO OUT PATIENTS DEPARTMENT AT GOVERNMENT RAJAJI HOSPITAL, MADURAI.

M.Sc. (NURSING) DEGREE EXAMINATION

BRANCH –IV COMMUNITY HEALTH NURSING

COLLEGE OF NURSING

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A dissertation submitted to

THE TAMILNADU Dr.M.G.R MEDICAL UNIVERSITY,

CHENNAI-600 032.

In partial fulfillment of requirement for the degree of

MASTER OF SCIENCE IN NURSING

APRIL-2016

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CERTIFICATE

This is to certify that this dissertation titled, "**A study to assess the psychological and social impacts of epilepsy among epileptic clients attending Neuro Out Patients Department at Government Rajaji Hospital Madurai"** is a bonafide work done by **Mrs. Shanmugam Sobarani,** College of Nursing, Madurai Medical College, Madurai-20, submitted to The TAMILNADU Dr.M.G.R MEDICAL UNIVERSITY, CHENNAI in partial fulfillment of the university rules and regulations towards the award degree of **MASTER OF SCIENCE IN NURSING**, **BRANCH-IV, COMMUNITY HEALTH NURSING** Under our guidance and supervision during the academic period from 2014 - 2016.

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ABSTRACT

Title: To assess the psychological and social impact on epilepsy among epileptic clients attending neuro outpatient departments at government Rajaji hospital madurai. **Objectives**: To assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patients department at government Rajaji hospital madurai. To compare the psychological and social impacts of epilepsy among male and female epileptic clients attending neuro out patients department at government Rajaji hospital, madurai. To associate the psychological and social impacts of epilepsy among epileptic clients with their selected socio demographic variable. To distribute the instructional module to reduce psychological and social impacts of epileptic clients attending neuro Out Patients Department at government Rajaji hospital, Madurai. **Conceptual frame work:** Modified Ida jean Orlando's professional response theory. **Methodology:** quantitative approach with descriptive design. Univariant non probability consecutive sampling technique was adopted. **Setting:** The study was conducted at Neuro outpatient department, Government Rajaji Hospital Madurai. Data collected by using standardized QOLIE-31 tool. Assessed psychological and social impacts of epilepsy (n=136) on day38, the data collection was over. **Conclusion:** The study revealed that was most of the clients were on moderate psychological and social impacts of epilepsy also there was a difference in male and female of psychological and social impacts at p 0.0001 level of significance. Based on one way ANNOVA selected demographic variables such as age, occupation, income, duration of illness and sleeping pattern was associated at P= <.000 level.

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INTRODUCTION

CHAPTER - I

INTRODUCTION

I didn't get my licence because I wasn't allowed to. But I haven't had a seizure for a long time so I could, theoretically, get my licence. But I'm now just so used to not driving; I'm scared of what I'd do.

- *Hugo Weaving*

Health is the level of functional or metabolic efficiency of a living organism. In human it is the ability of individuals or communities to adapt and self-manage when facing physical, mental or social challenges. The World Health Organization defined health in its broader sense in its 1948 constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." This definition has been subject to controversy, in particular as lacking operational value and because of the problem created by use of the word "complete" Other definitions have been proposed, among which a recent definition that correlates health and personal satisfaction. Classification systems such as the WHO Family of International Classifications, including the International Classification of Functioning, Disability and Health and the International Classification of Diseases, are commonly used to define and measure the components of health.

Systematic activities to prevent or cure health problems and promote good health in humans are undertaken by health care providers. Applications with regard to animal health are covered by the veterinary sciences. The term "healthy" is also widely used in the context of many types of non-living organizations and their impacts for the benefit of humans, such as in the sense of healthy communities, healthy cities or healthy environments. In addition to health

care interventions and a person's surroundings, a number of other factors are known to influence the health status of individuals, including their background, lifestyle, and economic, social conditions, and spirituality; these are referred to as "determinants of health." Studies have shown that high levels of stress can affect human health.

Epilepsy is one of the most prevalent neurological conditions and it knows no age, racial, social class, geographic, or national boundaries.The burden of epilepsy may be due to the physical hazards of epilepsy resulting from the unpredictability of seizures; the social exclusion as a result of negative attitudes of others toward people with epilepsy; and the stigma, as children with epilepsy may be banned from school, adults may be barred from marriage, and employment is often denied, even when seizures would not render the work unsuitable or unsafe.

Seizures are caused by malfunction of the brain’s electrical system. The manifestations of seizures are determined by the site of origin and may include unconsciousness or altered consciousness. In children it can occur with a wide variety of conditions involving the Central Nervous System.The onset of epilepsy is most commonly seen in childhood. Identification of risk factors, early recognition and appropriate management is crucial to prevent genesis of epilepsy.

Epilepsy can occur at any time and at any place. When it occurs in a school, the students as well as the teachers are alarmed at the sight of child’s seizure. Some believe that the child is dying. Many people impose unnecessary and unreasonable restriction on the child’s activities. That there is no proper awareness as also total misconception about the disease.

Complications of complex partial seizures are easily triggered by emotional stress. The limbic structures (i.e., hypothalamus, hippocampus, amygdala) of the brain

may be damaged by seizure activity. The limbic system is concerned with emotion and motivation.

Status epilepticus is a medical emergency in which seizures recur without the patient regaining consciousness between events. This condition can develop in any type of seizure but is most common in tonic-clonic seizures. Status epilepticus may cause brain damage or cognitive dysfunction and may be fatal. Subsequent seizures become briefer, more localized, and may be reduced to myoclonic activity.

The World Health Organization estimates that 3-10 per 1000 of world population have epilepsy. There may be as many as 40 billion epileptics as per statistics.Epilepsy itself is a very common medical condition that may occur among people of all ages, sex and races. Despite seizures may only last for a few seconds or a few minutes, it has much psychosocial repercussions to the patients and their family members1,2. As people with epilepsy are a highly diversified and complex group due to different aetiologies, the author will only focusthe discussion on those patients without other comorbidities like physical disability, cerebral palsy and mental retardation. The impact to individuals is also very unique. For those who have seizures at the workplace, feeling of embarrassment and guilt would be very strong. They will feel more helpless, rejected and frustrated in the midst of misunderstanding and gossips. Some patients may even lose their jobs directly or indirectly after seizures.

Another major impact on adults is the interpersonal relationship embracing friendship, courtship and marriage. Withdrawal from social lives, fear of rejection and worry over inheritance and pregnancy limit their social support network and establishment of new family support system in the long run. In addition, both anxiety and depressive symptoms are prevailing among adult patients in both local and

overseas studies. The chronicity of epilepsy, the unavailability of stable jobs, restricted social lives, lowered self-concept and family conflicts will further affect their quality of life.

A high number of patients with epilepsy have depressive illness and psychosis. They also have higher rate of suicidal attempts or ideation. They also have negative social skills and impaired coping mechanisms. Unemployment and higher anxiety states are more frequent for women with epilepsy as compared to men with epilepsy. Female patients have more difficulty finding life partners and have higher rate of divorce compared with males. Women with epilepsy rarely use constructive coping methods, and thus have poor psychosocial status and adjustment within the family and society.

A large proportion of Jordanian participants (88.5%) objected to the marriage of epileptic patients with epilepsy to the participants' children. One third of the respondents believed that epilepsy is more serious compared to diabetes mellitus and hypertension. The knowledge and attitudes of Jordanians towards epilepsy is almost similar to the results from Asia. However the results are more negative than results from the West.

Rudolf W.H.M. Ponds Mark Hendriks (2006) conducted a survey of community knowledge and attitudes toward epilepsy.Telephone interviews were conducted on 400 people aged more than 17 years old from a provincial town. Attitudes toward people with epilepsy were favorable. Ninety-five percent of the participants had knowledge about epilepsy. The respondents who were less knowledgeable were the younger people, the people with less education and lower socioeconomic status with those of Maori or non-European ethnicity. Only 5% of the

respondents objected to their children marrying an epileptic patient. Less positive attitudes were found among the older people.

Incidence, prevalence and mortality studies provide crucial measures of the frequency and therefore the burden of the disease and allow the planning of services. The applications of epidemiological techniques in the field of epilepsy have extended beyond the usual concept of prevalence and incidence.

The objectives of epidemiological studies also include; identification of risk factors for epilepsy and to estimate the effect of potential interventions; To determine overall prognosis for seizure control and the identification of factors which may modify this prognosis; To assess the risk for other conditions in both the patient as well as in relatives andTo evaluate interventions, including drug trials.

One of the most significant impacts on adult patients is employment opportunities. The severity of seizure activities, educational attainment and social skills will largely determine their vocational opportunities. Generally speaking, they need to avoid employment with potential risk to their own lives and the public such as driving buses. Certain job natures may trigger seizure activities like night shift work. For those who are working, patients are inclined to conceal their illness lest they will not be employed or even lose their jobs. Employers is a very stressful and prolonged process. On top of coping with the normal work stress, they are also suffering from the stress of managing their epilepsy identity.

For those who have seizures at the workplace, feeling of embarrassment and guilt would be very strong. They will feel more helpless, rejected and frustrated in the midst of misunderstanding and gossips. Some patients may even lose their jobs directly or indirectly after seizures. Another major impact on adults is the interpersonal relationship embracing friendship, courtship and marriage. Withdrawal

from social lives, fear of rejection and worry over inheritance and pregnancy limit their social support network and establishment of new family support system in the long run. In addition, both anxiety and depressive symptoms are prevailing among adult patients in both local and overseas studies12-17. The chronicity of epilepsy, the unavailability of stable jobs, restricted social lives, lowered self-concept and family conflicts will further affect their quality of life18.

These patients may develop cognitive and behavioral difficulties, such as the following interictal personality: humorlessness, dependence, obsessions, anger, hypo- or hypersexuality, emotionality, Memory loss: short-term memory loss attributable to dysfunction in the hippocampus, anomia, Poriomania: prolonged aimless wandering followed by amnesia, Violent behavior: aggression and defensiveness when subjected to restraint during a seizure

Complications associated with tonic-clonic seizures may involve injury, such as the following aspiration of secretions or vomited stomach contents, skull or vertebral fractures, shoulder dislocation, tongue, lip, or cheek injuries caused by biting, Status epileptics

Complications may include the aspiration, cardiac arrhythmias, dehydration, Fractures, Myocardial infarction, oral and head trauma, pulmonary edema, sudden Unexplained Death in Epilepsy. Sudden unexplained death in epilepsy occurs in a small percentage of persons with epilepsy. For reasons that are poorly understood, an otherwise healthy person with epilepsy can die suddenly. While this also happens within the general population, persons with symptomatic epilepsy have a much greater risk.

Approximately 50 million people currently live with epilepsy worldwide. The estimated proportion of the general population with active epilepsy at a given time is

between 4 and 10 per 1000 people. However, some studies in low- and middle-income countries suggest that the proportion is much higher, between 7 and 14 per 1000 people.

Globally, an estimated 2.4 million people are diagnosed with epilepsy each year. In high-income countries, annual new cases are between 30 and 50 per 100 000 people in the general population. In low- and middle-income countries, this figure can be up to two times higher.This is likely due to the increased risk of endemic conditions such as malaria or neurocysticercosis; the higher incidence of road traffic injuries; birth-related injuries; and variations in medical infrastructure, availability of preventative health programmes and accessible care. Close to 80% of people with epilepsy live in low- and middle-income countries.

There are very few incidence studies from India, and the most recent one suggests an age standardized incidence rate of 27.3/100,000 per year.There are no population-based studies on status epilepticus in India. Hospital data is biased. Non-convulsive status epilepticus is usually not identified as it requires electroencephalography facilities in the intensive care unit for diagnosis. In one study 10% of patients with altered mental status had Non-convulsive status epileptics. As compared with high income countries, the incidence and mortality rates of status epilepticus are likely to be higher in India, due to a higher proportion of central nervous system infections, delay in onset to hospitalization, and lack of diagnostic and treatment facilities. Studies from Luck now, Hyderabad, and Mumbai have amply confirmed this. One way of addressing the long delay to treatment would be to make more widely available the prehospital use of intramuscular or nasal or buccal midazolam.

Finally, it should be possible for neurologists and other health care professionals to adopt districts and engage with primary health centre staff and state government health officials to identify patients with epilepsy and treat them with phenobarbitone.

1.1 Need for the Study

Epilepsy has impacts on various aspects of social life of patient with epilepsy. These patients are less likely to get married and more likely to get divorced in comparison with the general population. This social problem can be attributed to the social stigmatization of epilepsy. Stigma is a degrading and debasing attitude of the society that discredits a person or a group because of an attribute such as an illness, deformity, color, nationality, religion, etc. The resulting coping behavior of the affected person results in internalized stigma. This perceived or internalized stigma by the discredited individual is equally destructive whether or not actual discrimination occurs. Stigma destroys a person's dignity, marginalizes affected individuals, violates basic human rights, markedly diminishes the chances of a stigmatized person of achieving full potential, and seriously hampers pursuit of happiness and contentment. On the contrary, externalized stigma refers to environmental issues surrounding the person through social discussion and judgment by culture and its dominant view.

Vocational issue is common in epileptic patients, as they have high unemployment rates and frequently work in underpaid jobs. One of the reasons for employment problems of patients with epilepsy is the attitude of employers. The problem is worse in the female patients as they have a higher rate of unemployment. Epileptic patients have difficulty in finding life partners or have children. There is a tendency for them to be single. They also have difficulties in achieving independence

in their life. A study was done in South Korea regarding employment of people with epilepsy. People with epilepsy have higher rate of unemployment at around 30% compared to general population. The people with epilepsy who are unemployed have significantly lower quality of life than the employed ones. The employability of people with epilepsy was influenced by the frequency and severity of seizures, age at onset, interseizure psychosocial disabilities including self-esteem, personality, and problem-solving style and social discrimination. There was stigmatization and misconception in employment of people with epilepsy. Nearly one quarter of the participants thought that they were treated unfairly at work or when trying to look for jobs. More than half of those who disclosed their disease to employers said that they were refused jobs due to their illness.

About 75% of the patients mentioned that they did not reveal their disease when applying for job. There was a study done in United Kingdom looking at the attitudes of employers to people with epilepsy. There were 204 respondents in the study. Nearly one quarter of the participants had experience of employing patients with epilepsy. Sixteen percent considered that there were no jobs in their company suitable for people with epilepsy. About 20% of the respondents thought that by employing people with epilepsy, it would be "a major issue." Employers believed that patients with epilepsy, even when in remission, should inform the condition of their illness to the employer.

Seizure severity and frequency are important when employers consider epileptic patients for employment, as half of the employers are worried of work-related accidents. They are willing to give flexible working hours to epileptic patients. Company size and type of company influence employability of people with epilepsyEpilepsy is associated with reduced quality of life. Patients with epilepsy

generally have impaired coping skills or mechanisms especially female patients. Patients who have seizures that are well controlled have better coping skills and better quality of life. However, socioeconomic status can be an additional protective factor. Important predictors of good outcome are good quality of life at the beginning and few side effects of therapy. Significant predictors of poor outcome were poor health perception and presence of depression. At least 50% of cases begin at childhood or adolescence.70% to 80% of people with epilepsy could lead normal lives if properly treated. In developing countries, 60% to 90% of people with epilepsy receive no treatment due to inadequate knowledge due to social stigma. Lack of knowledge increases the potential for inappropriate or inadequate responses by parents, teachers, coworkers, and the public at large to repetitive or prolonged seizures, and the associated discomfort about how to provide first aid also can contribute to the general stigma associated with epilepsy. Clinicians play a key role in educating patients, parents, caregivers, and the community about how to respond to an individual who is having a seizure.

In a similar study that Agarwal.et.al., conducted on 240 patients with epilepsy in India, it was found that patient with epilepsy's had a lower marriage rate than the general population and women with epilepsy had a higher divorce rate. Although attitude toward epilepsy has improved in recent years, negative public attitude toward epilepsy persists. Some people believe that patient with epilepsy's should not marry because their children might have epilepsy too although their seizures may be well controlled. Degree of noted negative ideas against patient with epilepsy's has been different in several countries and in different cultural situations. In addition to the public negative attitude, the perceived stigma of epilepsy in patient with epilepsy's can be attributed to this matter. We think that interaction between the externalized and

internalized stigma of epilepsy might have an impact on marital and sexual status in patient with epilepsy's.

There are no contraindications to the use of non-hormonal methods of contraception in women with epilepsy.There is also a decrease in childbirth rates in patients with epilepsy. The childbirth rate in female patients with epilepsy is 25% lower compared to women in the general population. Female patients with epilepsy have reduced sexual interest. In some female patients with epilepsy, the desire and arousal phases may be inhibited. As for treatment during pregnancy, the teratogenic risks of anticonvulsant drugs such as spina bifida and the seizure control of the pregnant mothers need to be balanced. Preconception counselling should be given to women with epilepsy who are thinking about getting pregnant. Female patients with epilepsy should be informed about certain issues, including methods and consequences of prenatal screening, labour, breast feeding and care of a child. Preconceptional folic acid is given to prevent major congenital malformations in the babies of women with epilepsy who are taking anticonvulsant medications.

During pregnancy, the lowest effective dose of the most appropriate anticonvulsant drug should be given. There is more teratogenesis with sodium valproate is than carbamazepineThe combination of sodium valproate and lamotrigine is especially teratogenic. Pregnancy probably causes increased amount in the clearance and decreased concentration of lamotrigine, phenytoin, and to a lesser extent carbamazepine. Pregnancy possibly decreases the concentration of levetiracetam and the active oxcarbazepine metabolite, the monohydroxy derivative. The majority of infants are delivered healthy with no increased risk of obstetric complications in female patients with epilepsy. Monitoring of lamotrigine, carbamazepine, and phenytoin levels during pregnancy should be considered.

Epilepsy has been observed to significantly ipact on the quality of life of the suffers. This concept of Quality of life in epilepsy encompasses physical health general health and daily function, seizure frequency and severity and miedcation side effects. Mental health emotional well being and self esteem and social (relationships with family and friends and perceived stigma resulting from the diagnosis of epilepsy. Individual patients definition of Quality of life is crucial to achieving the medical goal of seizure.

Patiens with epilepsy sufer social deprivation and discrimination in education, employment, housing, marital life amongst other components of daily living. Epilepsy is seen as a highly contagious and shameful disease in the yes of the public in the country. This socio cultural attitude continues to have a negative impact on the management of epilepsy and contributes to poor prognosis and development of complications. The general attitude toward patients with epilepsy is negative. Awaritefe et.al assessed the attitude of the normal literate general public towards person with epilepsy versus the 'cured' psychotic patient. The found tha the general attitude towards the epileptic patient is negative whereas toward the 'cured' psychotic patient it is positive .There were gender difference, in that males perceived epileptic patients more favourably than females did. However bothe male and female participants discriminated against both the epileptic and 'cured' psychotic person in terms of employment, residential accommodation, friendship and marital relationship.

Stigma associated with epilepsy in some instances appears to be of greater hindrance that the side effect of the antiepileptic medication. Also the opportunity for marriage and employment are substantially worse for people living with epilepsy and its impact on daily living has been shown to be destructive.

The impact of stigma on impaired psychological and social function and quality of life of people with epilepsy has been well documented. Schneider & Conrad point out that and invidiuals experience of epilepsy is not simply a direct result of the medical severity of the seizures. But is also related to its social meaning and reality. Stigma in epilepsy is associated with both legitmated and non-legimated discrimination and social exclusion, often with marked impacts on quality of life.

Strategies focusing on stigma, public awareness and knowledge, and social and rehabilitation support within the context of the community are foremost designed to decrease te social burden, prejudice and discrimination faced by people with epilepsy.

Greater awareness is needed of the wider psycholigal and social impacts of epilepsy. Improved training of health professionals is required, as are resources for public awareness campaigns. Anxiety and other negative reactions are more likely to develop when people have partial and / or inaccurate information. People need pertinent, individually tailored information about seizures, treatment and lifestyle. Input is needed not only at the time of diagnosis. Epilepsy is a complex disorder and the need and nature of support will change over time. Epilepsy nurse specialists have a crucial role in providing education, information and emotional support to people with epilepsy and their families. So the researcher interested to do the assessment of psychological and social impact on epilepsy among epileptic client.

1.2 Statement of the problem

A study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro Out Patients Department at Government Rajaji Hospital, Madurai.

1.3 Objectives of the study

- To assess the psychological and social impacts of epilepsy among epileptic clients attending neuro Out Patients Department at Government Rajaji Hospital, Madurai
- To compare the psychological and social impacts of epilepsy among male and female epileptic clients attending neuro Out Patients Department at Govt Rajaji Hospital, Madurai.
- To associate the psychological and social impacts of epilepsy among epileptic clients with their selected socio demographic variable.
- To distribute the instructional module to reduce psychological and social impacts of epileptic clients attending neuro Out Patients Department at Government Rajaji Hospital, Madurai.

1.4 Hypotheses

H_1: There is a significant difference on psychological and social impacts of epilepsy between male and female clients attending neuro out patients Department.

H_2: There is a significant association between the psychological and social impacts of epilepsy with their selected socio demographic variables.

1.5 Operational definitions

Psychological impact

In this study it refers to disturbance in all individual's cognitive, emotion regulation, or behavior and it will be measured by using quality of life scale.

Social Impact

In this study it refers to the effects like marriage, employment, and social functions and it will be measure by quality of life scale.

Epilepsy

In this study it refers to a neurological condition characterized by recurring fits due to disturbed electrical activities of the brain cells of the human being.

Epileptic Client

In this study it refers to the clients who were already diagnosed as epilepsy attending neuro out patient department.

Neuro Outpatient Department

In this study it refers to epileptic clients visiting to neuro outpatient department who is not hospitalized overnight but visit to clinic associated facility for diagnosis and treatment of epilepsy.

1.6 Assumption

- Epileptic clients are unable to overcome the social function, intellectual memory, concentration and marital impact etc.
- Epileptic clients psychological and social impact will be vary from person to person.

1.7 Delimitation

The study was limited to,

- Epileptic clients attending Neuro out patients department in Government Rajaji Hospital, Madurai.
- Data collection period was limited to 4 to 6 weeks only.

1.8 Projected outcome

The study result will show the evidence of psychological and social impacts of epileptic clients.

CHAPTER-II

REVIEW OF LITERATURE

CHAPTER - II

REVIEW OF LITERATURE

A literature review is an evaluative report of information found in the literature related to selected area of study. The review should describe, summarize, evaluate and clarify this literature. It should give a theoretical base for the research and help you determine the nature of your research. Works which are irrelevant should be discarded and those which are peripheral should be looked at critically.

A literature review is more than the search for information, and goes beyond being a descriptive annotated bibliography. All works included in the review must be read, evaluated and analyzed (which you would do for an annotated bibliography), but relationships between the literature must also be identified and articulated, in relation to your field of research.

This chapter deals with two sections.

Part - A: **Review of Literature**

Part - B: **Conceptual framework based on Ida Jean Orlando Professional Response theory**

Part - A Review of literature

The literature has been organized under following sections:

2.1 Literature related to psychological and social impacts on epilepsy

2.2 Literature related to epilepsy and employment

2.3 Literature related to epilepsy and cognitive impairment

2.4 Literature related to rehabilitation

Part - A

2.1 Literature related to epilepsy and quality of life

Mahrer-Imhof, Jaggi, Bonomo, Hediger, Eggenschwiler et.al, (2013) assessed the Quality of Life in adult patients with epilepsy and their family members among 104 dyads of patient and family members at the subjective Quality of Life in patients and family members differed significantly, as did satisfaction with care delivery. Family support contributed significantly to Quality of Life. The Quality of Life of the family members was affected by the patient's knowledge about the disease and the reason for their current hospitalization but patient Quality of Life scores had no influence on the Quality of Life of their family members. The study revealed that the patients' Quality of Life depended significantly on the Quality of Life of the family members. Patient and family centered approach is therefore emphasized.

Melikyan, Guekht, Milchakova, Lebedeva.et.al, (2012) conducted the socio-demographic and clinical factors influencing the health-related Quality of Life of 208 adult patient with epilepsy at Russia. They obtained lower mean Quality of LifeIE-31 scores. There was a negative correlation between duration of epilepsy with all Quality of LifeIE-31 subscores ($p<0.05$), except for emotional well-being ($p=0.1$). Depression score was the predictor of overall score and all Quality of LifeIE-31 domains, except for emotional well-being. Age was a predictor of cognitive and social functioning, medication effects and the total Quality of LifeIE -31 score. The study concluded that seizure frequency was associated with all health related Quality of Life domains, except medication effects and emotional well-being.

Shakirand Al-Asadi (2012) conducted the Quality of Life and its determinants in People with Epilepsy in Basrah, Iraq on comparison of 116 patient with epilepsy with healthy controls, the monthly family income among patient with epilepsy showed that 43.1 % were medium income earners, while most of them in the control group 44.8 % were high income earners. Unemployment was the most frequent problem in 60.3% of patient with epilepsy , 56 % were unmarried, while most of them in the control group were employed 53.4% and 71.6% were married. The mean total Quality of Life score of epileptic patients was 47.9 ± 18.1 as compared to 71.7 ± 10.2 in the control group with a highly significant difference ($P < 0.001$). Most epileptic patients had poor to moderate Quality of life with a highly significant difference ($P< 0.001$). Patients with low educational levels and low income also had lower Quality of life scores, with a significant association. The study concluded that predictors of better Quality of Life was younger age, higher levels of education and family income and the clinical predictor was seizure activity.

Viteva (2012) assessed the impact of perceived stigma on the Quality of Life of 70 Bulgarian patients with refractory epilepsy. The mean disease duration was 25.1±1.3 years. 40.0% of patients (±5.9) had symptomatic epilepsy. Seventeen patients (24.2%±5.1) had partial seizures, 16 (22.8%±5.0) had generalized seizures and 37 (52.9±6.0) had a mixture of partial and generalized seizures. Perceived stigma was found among 43.6% of the patients with refractory epilepsy, and 28.7% of the patients selfreported of having experienced severe stigmatization. Only 4 (5.7%) patients with pharmacosensitive epilepsy reported stigmatization which was mild or moderate in all cases. Perceived stigma had a negative impact on the overall score of the Quaity of life-89 (T-score 47.8), as well as on all subscales of Quality of life-89, with the exception of "change in health" and "sexual relations". The study concluded

that patients with refractory epilepsy reporting stigmatization most commonly had very low scores on the subscales "health perceptions" (82.9%), "emotional well-being" (71.5%), "memory" (63.4%) "health discouragement" (62.5%).

Noble, Goldstein, Seed, Glucksman&Ridsdale (2012) conducted a prospective study among 85 people with epilepsy attending emergency departments where the characteristics of the mean age as 41; 53% were male, average number of emergeny department attendances in the prior year (mean 3.2; median 2) exceeded that of other emergeny department users and those with most chronic conditions. Some patients attended emergeny department frequently. Compared to the general epilepsy population, emergeny department attendees experienced more seizures, anxiety, had lower level of knowledge on epilepsy and its management and greater perceived epilepsy-related stigma. The study concluded that in descending order, lower knowledge, higher perceived stigma, poorer self-medication management, and seizure frequency were associated with more emergency visits.

Quintas, Raggi, Giovannetti, Pagani, Sabariego, Cieza&Leonardi (2012)conducted a study to identify the Psychosocial difficulties in people with epilepsy found that the most frequent Psychosocial difficultiesthey found in people with epilepsy were depressive symptoms, memory functions, Quality of life, anxiety, stigma, locus of control, cognitive functions in general, and emotional functions in general. The patients' life areas were affected by cognitive, emotional,and psychological problems.

Renato.et al., (2012)conducted a study tocorrelation coefficient study aimed at identifying Quality of life issues and occupational performance of persons with epilepsy determined that the most affected domains of Quality of life in epilepsy-31

were seizure worry, it was nearly 29.77% about and effects of drugs were 49.75% For the Occupational Performance Measure, the average of performance and satisfaction were 3.10% and 4.45% , respectively and performance limitations most frequently cited were maintenance of employment, left home alone and courses. The study showed that the three main performance limitations posed by the Occupational Performance Measure identified that a level of satisfaction influenced the perception of Quality of life.

Li Yue, Pei-min Yu, De-hao Zhao.et al., (2011) identified the determinants of Quality of Life in people with epilepsy and their gender differences. Perceived adverse effects of treatments and number of anti epileptic drugs had a greater influence on Quality of Life in women, whereas anxiety and seizure-related variables had a stronger impact on Quality of Life among men. The researchers suggested that individualizing interventions to improve the Quality of life of people with epilepsy would improve Quality of life.

Nitin, Ray, Reshma, Shruthi, Herady, Kumar &Kiran (2011) conducted a cross-sectional study at Mangalore, India among epileptic patients in the age group of 7 or more by an interview among 56 patients assessed the Quality of Life, and stigma associated and self-management practices among patients suffering from epileptic seizures, In that 55.4% patients had general tonic clonic seizures and 80.4% had multiple episodes of seizures. Quality of Life and Self management practices were good in 44.6% and 71.4% patients. Self-management practices were found to significantly improve with age of patients (P=0.012). Educational status of patients was found to significantly improve their Quality of Life and selfmanagement practices (P=0.031). Stigmatization was reported by 66.1% of the patients and it was

significantly more in patients in the age groups of 30 to 50 years (P=0.043). Self-management practices were good in most patients but this was not so with Quality of Life or experience of stigma. The authors suggested that this could be improved by educating the people in order to generate greater social support for epileptic patients.

Lua&Selamat (2011) investigated the relation of Awareness Knowledge and Attitude to health-related Quality of Life within across all patients. Both Awareness, Knowledge and Attitude levels the median was 80.0, range: 0–170 overall health related Quality of life the median was 51.5; range below 15–97 were moderate. Awareness was significantly correlated with Seizure Worry, $p < 0.05$), whereas knowledge was not significantly linked to any domain. Attitudes was significantly correlated with all domains $p < 0.01$) except Medication Effects and Seizure Worry. Patients with good Awareness, Knowledge and Attitude levels experienced significantly better Quality of life and Cognitive Functioning ($p < 0.05$). The researchers suggested that enhancing Awareness, Knowledge and Attitude through epilepsy awareness might help in improving health outcomes.

Pandey, Sahoo&Sayeed (2010)conducted a study to compared the Quality of life and marital adjustment in epilepsy with psychiatric illnesses among 30 patient with epilepsy and 60 psychiatric patients. The findings revealed that 60 % of the patient with epilepsy had better social relationships as compared to 61.7% patients with psychiatric illness. 60% of patients diagnosed with epilepsy showed a good adjustment with their spouses as compared to 73.3% with psychiatric illness who had poor adjustment. Both the patient with epilepsy and people with psychiatric illness had poor Quality of Life in 61.7% and 63.3% respectively. Both types of illnesses

have similar impact on Quality of Life in the domains of psychological, physical and environmental Quality of Life.

Sancho, Iváñez, Molins, López Gómez.et al, (2010)conducted 6-months observational, prospective, multicenter study among 262 patients diagnosed with partial epilepsy and receiving two antiepileptic drugs. Reductions in seizure severity were detected from baseline to 3 months and 6 months ($P < 0.0001$). Improvements compared with baseline were found for Hamilton Anxiety and Depression scales ($P < 0.0001$), most Medical Outcomes StudySleep subscales ($P < 0.05$), and seven subscales of Quality of Life in Epilepsy Inventory-31 (Quality of Life in epilepsy-31; $P<0.0005$). The study concluded that seizure severity correlated directly with anxiety ($P<0.0001$) and inversely with Quality of Life in epilepsy-31 measures ($P< 0.0001$).

Eddy, Rizzo, Gulisano, Calì, Robertson &Cavanna (2010) conducted a care control study in that comparison of 50 young patients with controlled epilepsy and 102 healthy controls reported increased anxiety ($P = 0.037$) and more emotional and behavioral difficulties ($P < 0.001$) among the young patients with controlled epilepsy. They study concluded that though there were no difference between the groups in Total Quality of Life score, treatment-responsive epilepsy was associated with lower Quality of Life within the Self domain ($P= 0.016$).

Babu, Satishchandra, Sinha &Subbakrishna (2009)conducted prospective case- control study in resource poor setting among 250 patient with epilepsy attending neurology outpatient services in the age ranging from 16 to 60 years compared with healthy matched controls. The type of epilepsy revealed that 62.4%, had generalized, 21.6% complex-partial, 8.8% simple-partial and 7.2% hadunclassified seizures respectively. 69% were on monotherapy, and rest on

polytherapy, with 90.8% on adequate dosages of anti-convulsants. 83.2% were compliant and 70.4% had satisfactory control of seizures. One co-morbid condition was noted in 152 (60.8%) cases and among them, 62 (24.8%) had 2 co-morbidities. Control population was also evaluated for the presence of same co-morbidities andcompared with cases.

Ohaeri, Awadalla& Farah (2009) assessed the Quality of Life in 276 Sudanese with grand-mal seizures and their caregivers, using the world health organization 26-item Quality of Life found that the Quality of Life scores of patients were rather poor of (50.6 -60.8%), and significantly lower than the control group. The scores being physical health domain was 57.1%, psychological was 60.1%, social relations 58.4%, environment was 50.6% and general fact was 60.8%. They had lower environmental domain scores than Sudanese diabetes patients. Caregivers had significantly higher scores (57.4 -73.7%) than patients and control group. The study revealed that there was a significant concordance between patient's and caregiver's rating. The higher Quality of life of the patients was associated with marriage, education, employment.

Sachin, Padma, Bhatia, Prasad, Kumar &Tripathi (2008) evaluated the psychosocial impact of epilepsy in women between 15 and 40 years of age with epilepsy, compared to those with migraine and healthy, pregnant women. Amongthree groups of women, 100 women with epilepsy, 50 with migraine and 100 healthy, over a two-year period of assessment using questionnaires for identifying the Quality of Life, coping strategies and caregiver burden, it was found that Quality of Life was least, and the burden experienced by the caregiver was significantly more in patients with epilepsy ($p \geq 0.001$). Women with epilepsy relied more on religion/faith as a

coping method (p ≥0.021), and less on problem solving strategies (p ≥ 0.001) when compared to those with migraine. When compared to healthy / pregnant women, they employed religious methods of coping and denial (p≥ 0.001), with significantly less use of problem solving techniques, acceptance, positive and negative distraction (p ≥ 0.001). The study concluded that less frequent seizures, better education and remission sustained for atleast six months, were associated with better Quality of Life.

Senol, Soyuer, Arman &Ozturk (2007) identified the influence of fatigue, depression, clinical, demographic, and socio-economic factors on the Quality of Life of patients with epilepsy among 103 adult patients. The mean age of the patients was 34.3 ± 12.6, and mean duration of disease was 12.6 ± 9.3 years. Among these patients, 52.4% were men, 49.5% were married, 15.5% had a university education, 53.4% had low income, 45.6% had generalized seizures, and 35.0% had experienced one or more seizures per month during the preceding year. The most significant variables in the domain of overall Quality of Life was seizure frequency (P < 0.001), depression (P < 0.001), and fatigue (P < 0.001); the variables in the domain of Mental Health were seizure frequency (P < 0.001) and fatigue (P < 0.001); the variable in the Cognitive domain was fatigue (P < 0.001); the variables in the domain of Physical Health was social insurance coverage (P < 0.01), fatigue (P < 0.01), and age (P < 0.01); the variables in the Epilepsy Targeted domain were depression (P < 0.001), seizure frequency (P < 0.001), and fatigue (P < 0.01).This studyconcluded that one or more seizures per month, severe fatigue, and depression were associated with lower Quality of Life in some domains. Fatigue was a significant independent predictor of Quality of Life.

Raty& Wilde Larsson (2007) reported the highest Quality of Life was in relation to the family domain, and the lowest, in relation to the psychological/spiritual domain among 102 young adults with uncomplicated epilepsy. They suggested that uncomplicated epilepsy did not significantly affect Quality of Life in young adults and that the risk of social isolation due to uncomplicated epilepsy was not increased.

Alanis, Peña, Corona, López-Ayala.et al,(2005) identified the most strong predictors for a lower QoLIE-31 total score after multiple among 401 patients with sleep disorders ($P < 0.001$), socioeconomic status ($P < 0.001$), female gender ($P = 0.002$), and high seizure frequency ($P = 0.001$). Depression and time of evolution of epilepsy did not have any significant influence on quality of life-31 scores.

2.2 Literature related to epilepsy and employment

Smeets.et al., (2007) Employment and epilepsy to determinate of overall quality of life for the person with epilepsy. However, people with epilepsy often have difficulty finding and maintaining employment and have higher rates of unemployment and underemployment than the general population. The causes for this are multiple and complex. There is a direct impact of seizure frequency and severity, with more frequent seizures correlating with lower employment rates. Associated intellectual disability, cognitive impairments related to seizures and anti-epileptic medication, and negative impact of childhood onset seizures on school achievement also contribute. Psychosocial issues ranging from epilepsy associated mood disorders, lack of access to transportation, and the impact of seizures on self-esteem are further examples of challenges to full employment. Unfortunately, people with epilepsy also continue to face fear, misunderstanding and workplace discrimination. State and

federal vocational rehabilitation programs are available to help unemployed people with qualifying disabilities such as epilepsy overcome barriers to employment.

2.3 Literature related to epilepsy and cognitive impairment

Katherine Noe MD, Ph.D (2015*)* Conducted a study to the impact of epilepsy is one of the most prevalent neurological conditions and it knows no age, racial, social class, geographic, or national boundaries. The impact of epilepsy rests not only on the individual patient, but also on the family and indirectly on the community. The burden of epilepsy may be due to the physical hazards of epilepsy resulting from the unpredictability of seizures; the social exclusion as a result of negative attitudes of others toward people with epilepsy; and the stigma, as children with epilepsy may be banned from school, adults may be barred from marriage, and employment is often denied, even when seizures would not render the work unsuitable or unsafe. This study reveals that epilepsy is a disorder associated with significant psychological consequences, with increased levels of anxiety, depression, and poor self-esteem compared with people without this condition.

Christian E Elger Christoph Helmstaedter.et al, (2014) conducted a study on Chronic epilepsy and cognition. Cognitive profiles in epilepsy are as heterogenous as the epileptic syndromes themselves; causes, topography of epileptogenic areas, pathogenetic mechanisms, and the diverse features characterising the clinical course all contribute to the effect on cognition. There is evidence that cognitive functions are already impaired at the onset of the disease, and that the maturation of cognitive functions in children is susceptible to the adverse influence of epilepsy. In adults, cognitive decline progresses very slowly over decades with an age regression similar to that of people without epilepsy.

ChristophHelmstaedter PhD, MartinKurthenMD.et al., (2013) conducted a study to a longitudinal study in temporal lobe epilepsy. It remains unclear whether uncontrolled epilepsy causes mental decline. This longitudinal study contrasts change of memory and nonmemory functions in 147 surgically and 102 medically treated patients with temporal lobe epilepsy. All participants were evaluated at baseline and after 2 to 10 years. Surgical patients underwent additional testing 1 year postoperatively. Data were analyzed on an individual and group level. Fifty percent of the medically treated and 60% of the surgical patients showed significant memory decline at with little change in nonmemory functions (difference not significant). Surgery anticipated the decline seen in the medically treated group and exceeded it when surgery was performed on the left, or if seizures continued postoperatively. Seizure-free surgical patients showed recovery of nonmemory functions ($p < 0.001$) and of memory functions ($p = 0.03$). Multiple regression indicated that retest interval, seizure control, and mental reserve capacity as predictors of performance changes. In addition, psychosocial outcome was better when seizures were controlled. This study revealed that chronic temporal lobe epilepsy is associated with progressive memory impairment.

Carl B. Dodrill (2012) conducted a correlational and longitudinal studies to Progressive cognitive decline in adolescents and adults with epilepsy. The effects of an accumulation of single seizures upon mental abilities in adolescents and adults is explored through a selective review of the world's literature. The papers reviewed were divided up into cross-sectional and longitudinal studies. Of 16 investigations meeting all requirements for inclusion, 12 produced results pointing to a relationship between seizures and adverse cognitive change. Stronger results than the longitudinal

ones, no doubt because the effects of co-existing factors not related to seizure effects were included in measures of cognitive decline. The longitudinal study concluded that mild but thereis a definite relationships between seizures and mental decline.

Esther Strauss, DavidLoring, Michael Hunter.et al.,(2008) conducted a study to predict cognitive impairment with epilepsy in bozeman epilepsy consortium among a 1141 patient with medically refractory seizure. We examined the contribution of age of seizure onset, seizure duration, seizure laterality, seizure location, gender, handedness, and cerebral speech representation to cognitive attainment. The combined influence of the predictor variables was modest. Age of seizure onset was the best single indicator of Full Scale IQ (partial r = .23) and General Memory (partial r = .20). Laterality and location of dysfunction, and cerebral speech dominance were also relevant and independent indicators of aspects of cognition. Except for age of onset of seizures however, the magnitude of the effects was limited.

K.Das, M. Banerjee, G.P.Mondal.et al.,(2007) conducted a study to evaluate socio-economic factors causing discontinuation of epilepsy treatment resulting among 1450 patients with epilepsy who were recurrently followed up at an intervals of 2 months from 05 January to 06 January; 620 patients discontinued their treatment. In the developing countries, the major problems of epilepsy are lying in the treatment gap and discontinuation of treatment due to various adverse socio-economic factors. Among them 88.7% patient had breakthrough seizures for more than in two occasions. Socio-economic factors in respect to the treatment were evaluated during the follow-up period vis-a-vis income and expenditure, unemployment status,

negative attitude towards medical treatment, non-availability of drugs locally, co-morbid psychiatric and other illnesses, polytherapy and socialillusional thoughts about epilepsy.

Smeets.et al., (2007) conducted a study to employmentand over allquality of life for the person with epilepsy. However, people with epilepsy often have difficulty finding and maintaining employment and have higher rates of unemployment and underemployment than the general population. The causes for this are multiple and complex. There is a direct impact of seizure frequency and severity, with more frequent seizures correlating with lower employment rates. Associated intellectual disability, cognitive impairments related to seizures and anti-epileptic medication, and negative impact of childhood onset seizures on school achievement also contribute. Psychosocial issues ranging from epilepsy associated mood disorders, lack of access to transportation, and the impact of seizures on self-esteem are further examples of challenges to full employment. Unfortunately, people with epilepsy also continue to face fear, mis-understanding and work place discrimination.

2.4 Literature related to rehabilitations

R.D.Dennerll, E.A.Rodin, S.Gonzalez, et al,(2007)conducted a study to Neurological and Psychological Factors related to Employability of Persons with Epilepsy. Employed adults, Unemployed adults, and a Prevocational Group of young persons primarily in the 11th and 12th grades were participated in this study. An interdisciplinary research project was initiated for systematic, long-term study of employability prognosis of persons with epilepsy. Neurological, psychological, and occupational status variables were investigated in three groups of epileptics: The

study concluded that significant differences between Unemployed and Employed adult epileptics on a substantial number of measures that relate to employability suggesting a continuum of employability from very poor employability prognosis to very good prognosis. This study revealed that social adaptive abilities appear to be as important as seizure control, and perhaps even more important in the final outcome.

Part - B

Conceptual Framework

The Conceptual Framework for the present study was based on **Ida Jean Orlando's professional response theory** which focus on client's immediate need and determining if the needs were achieved with nursing action (Schmieding, 1998). The present study was focused to assess the psychological and social impacts of epilepsy among epileptic clients. The framework of the study was based on Ida jean Orlando's deliberate interactive model. To Ida Orlando, the client is an individual with a need that, when met diminishes depression, increases independability (or) enhances well being.

Patient behavior

It can be verbally expressed by language such as complaints requests, demands (or) refusals manifested physiologically such as apprehension, restless, reduced sleep, feelings, reduced motor activity or over activity and non verbal communication must be considered as expression of need for help and needs to be validated. In this present study the research to assessed seizure worry, emotional well being fatigue, cognitive function, overall quatiy of life, Medication effect, social functions.

Nurse reaction

Patient behaviour stimulates a Nurses reaction. The beginning of Nurse – patient relationship takes place. Nurse reaction to a patient's behavior forms the basis for determining how a nurse acts; it consists of perception through any senses, thought and automated feeling. It this present study the nurse reaction is to assess the psychological and social impact of epilepsy by QOLIE 31 scale.

Nurse activity

Nursing activity is what ever the nurse says (or) does to benefit the patient. Nurse activity can be automatic (or) deliberative. Automatic reactions are nursing behaviours that are performed to satisfy an order or regulations that may have no baring on the patients need for help. Automatic reactions include giving psychological support, social support by a Nurse, psychologist or any health care personnel. Deliberative reactions is a disciplined professional response while all of nursing actions could be considered to be in the patients best interest or deliberative. In this study distribution of instruction module includes enchancement of memory, social interpersonal relationship, cognitive behaviroal activity social network and self help group for their employment.

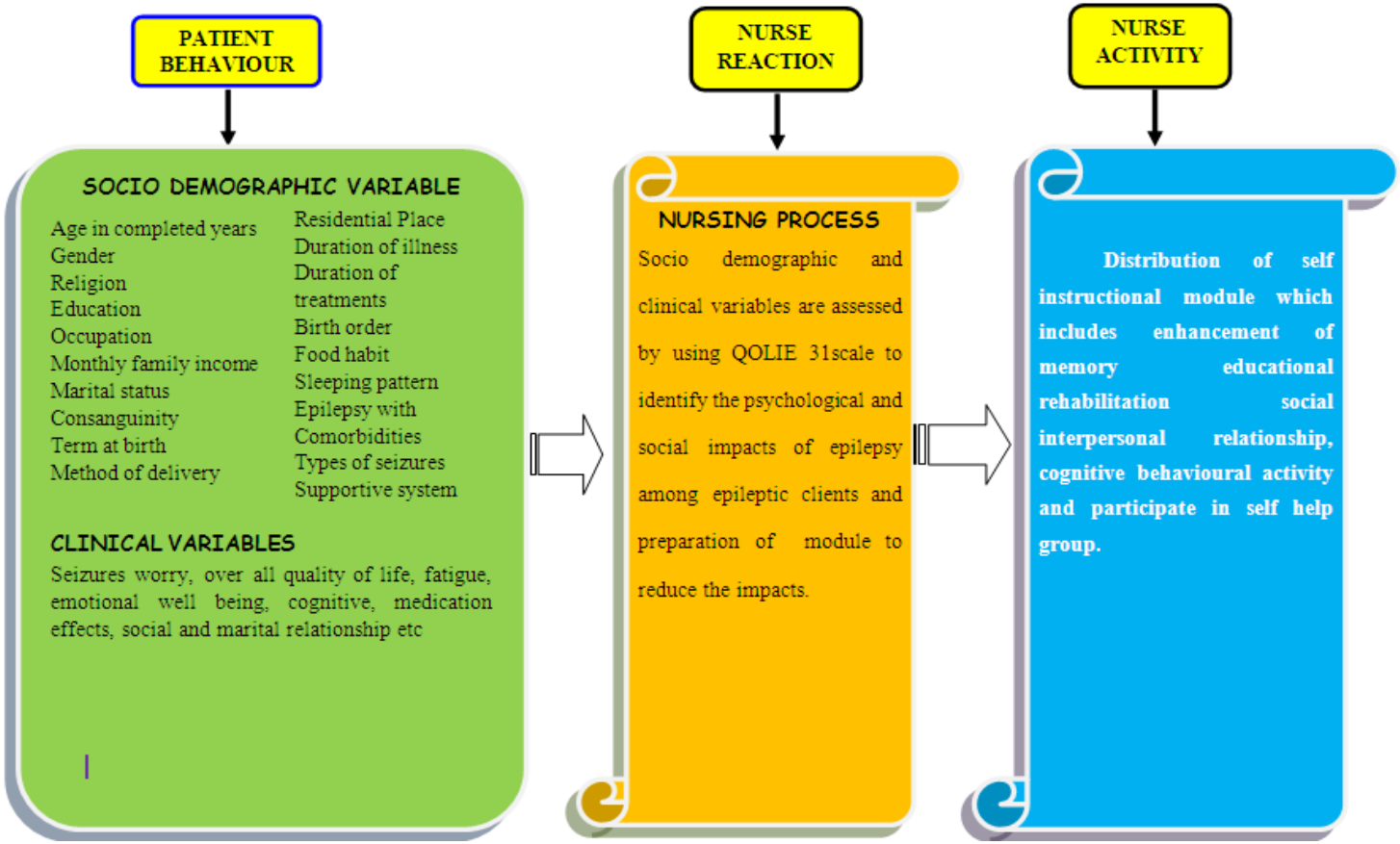


FIGURE -1 MODIFIED IDA JEAN ORLANDO'S THEORY (1961)

CHAPTER-III

RESEARCH METHODOLOGY

CHAPTER - III

RESEARCH METHODOLOGY

Methodology is a systematic way to solve the research problems. The research methodology in values the systematic procedure by which the investigator starts from the initial identification of problem to its final conclusion.

This chapter includes research approach, research design, variables, setting, population, sample, sample size, sampling technique, development of tool, content validity, pilot study, data collection procedure, plan for data analysis and protection of human rights.

This present study was done to assess the psychological and social impacts on epilepsy among epilepsy client's patients attending neuro outpatient department at government Rajaji hospital in Madurai.

3.1 Research approach:

Quantitative approach was used for this study

3.2 Research design:

The research design selected for the present study was univarant descriptive design. Univarant descriptive design are undertaken to describe the frequency of occurrence of a phenomenon. This design is mainly used to identify and describe the perception, knowledge, behavior, attitude, awareness and practice of the people etc.,

In this study researcher mainly assess the psychological and social impacts, like seizures worry, quality of life, emotional well beings, fatigue, cognitive, medication effects and social and marital relationships etc.,

3.3 Research variables:

Dependent variable

Psychological and Social impacts.

Demographic variable

Age, sex, religion, education, occupation, family income, marital status, consanguinity, method of delivery, duration of antenatal period, residence, duration of illness and treatment, birth order, food habits and sleeping pattern, comorbidities, types of epilepsy, support system.

Clinical variables (psychological and social impacts)

Seizures worry, emotional well being, fatigue, cognitive, medication effects, social and marital relationship etc.

3.4 Setting of the study

The setting was selected based on acquaintance of the investigator with the institution, feasibility of conducting the study, availability of the sample, permission and proximity of the setting to investigation.

The study was conducted in neuro outpatient department at government Rajaji hospital, Madurai.

3.5 Population

Target population

Clients with epilepsy on treatment.

Accessible population

Clients with epilepsy on treatment attending epilepsy neuro Out Patient Department, government Rajaji hospital, Madurai.

3.6 Sample

Clients with epilepsy attending neuro Out Patient Department, government Rajaji Hospital, Madurai Who fulfill the inclusion criteria.

3.7 Sample size:

Sample size of the present study was 136 Clients from this 68males and 68 females.

3.8 Sampling technique:

The researcher adopted non probability – consecutive sampling technique to select the Clients for the study.

3.9 Method of sample selection:

The researcher selected samples in neuro outpatient department based on the inclusion criteria. 136 samples were selected. Pretest was conducted for each selected samples by QOLIE 31 scale about 35 to 45minutes. When the next visit of the clients the researcher prepared a instructional module it consist of vocational rehabilitation enhancement of memory, self help group, improve the social interpersonal relationship and cognitive behavioural activities. Before giving the instructional module the researcher explained the do's and don'ts.

3.10 Criteria for sample selection

Inclusion criteria:

- Epileptic clients, both males and females who were attending neuro Out Patient Department, Government Rajaji Hospital, Madurai.
- Age group between 15-50 years.
- Clients who were willing to participate.
- Clients who were married and living with partners.

Exclusion criteria:

- Who have other associated illness, mental retardation and physical disability
- Who have eye and hearing problem.
- Clients who are unmarried separated and widower.

3.11 Research tool

Development of the tool:

A standardized questionnaire was used on the objectives of the study through review of literature, related studies, journals and books, opinion of experts. All these helped in the ultimate development of the tool. The tool is having positive and negative questions.

3.12 Description of the tool

Section I: Demographic variables include age, sex, religion, education, occupation, family monthly income, marital status, consanguinity, delivery method, pregnant period, residence, duration of illness and treatment, birth order, food habits and sleeping pattern, epilepsy with Comorbidities, types of epilepsy, support system.

Section II: 30 questions consist of psychological and social impacts which affect the quality of life in epileptic clients. It includes seizures worry, fatigue, emotional well beings, overall quality of life, cognitive impairment, medication effects and social functions etc.

3.13 Scoring procedure:

Likert scale was used for scoring. This scale contains 6 points, 5 points and 4 points

Psychological and social impact:

Seizure worry is assessed by 6 points scale.

Overall quality of life is assessed by 5 points scale.

Emotional well being is assessed by 6 points scale.

Fatigue is assessed by 5 points scale.

Cognitive function is assessed by 5 points scale.'

Medication effect is assessed by 5 point scale

Social function is assessed by 4 points scale.

Scoring interpretation

0% - 20%	Very low
21%– 40%	Low
41%– 60%	Moderate
61%– 80%	High
81% – 100%	Very high

3.14 Testing the tool:

Content validity:

The study was validated by 3 nursing experts and the Associate Professor of preventive and Social Medicine and the Professor of Neuro Medicine. All the experts have their consensus and then the tool was finalized. Experts were requested to judge the items for the clarity, relevance, comprehensiveness and appropriate of the content. Appropriate modification was made in each part as per the suggestion given by the experts.

Reliability of the tool

The tool was administered to 10 samples representing the characteristic of the population. The reliability coefficient was calculated through inter rater method. The co-relation co-efficient was r = 0.971. The tool was found to be highly reliable.

3.15 Pilot study

Pilot study was conducted after getting permission from the Medical Superintendent and Professor of Neuro medicine from 01.06.2015 to 07.06.2015. 10Samples were selected. Brief instruction was given about self and the study was explained. Written consent was obtained from the Clients and confidentiality was assured. The study samples were assessed by QOLIE 31 standardized tool. Findings of the study revealed that 4% of lower psychological and social impacts, 5% of moderate and 1% of High of Psychological and social impacts. From the pilot study findings the study setting was feasible and the tool was applicable to conduct the main study.

3.16 Data collection procedure

The main study was conducted for 6 weeks at epileptic outpatient department. Formal permission was obtained from the Medical Superintendent and Professor of Neuro medicine. Brief instruction was given about self to the Clients and established rapport with them. Selected samples were those who fulfill the inclusion criteria. The purpose of the study was explained and assured confidentiality. Both verbal and written consent was obtained from the clients. Interview methods by standardized questions were used to collect a psychological and social impact of epilepsy. The investigator visit daily to epileptic outpatient department from 01.08.2015 to 07.09.2015 to collect data.

3.17 Plan for data analysis

The collected data was organized, classified, grouped and analyzed on the basis of descriptive and inferential statistics.

Descriptive statistics

Frequency and percentage distribution were used to analyze the socio demographic variables of epileptic clients.

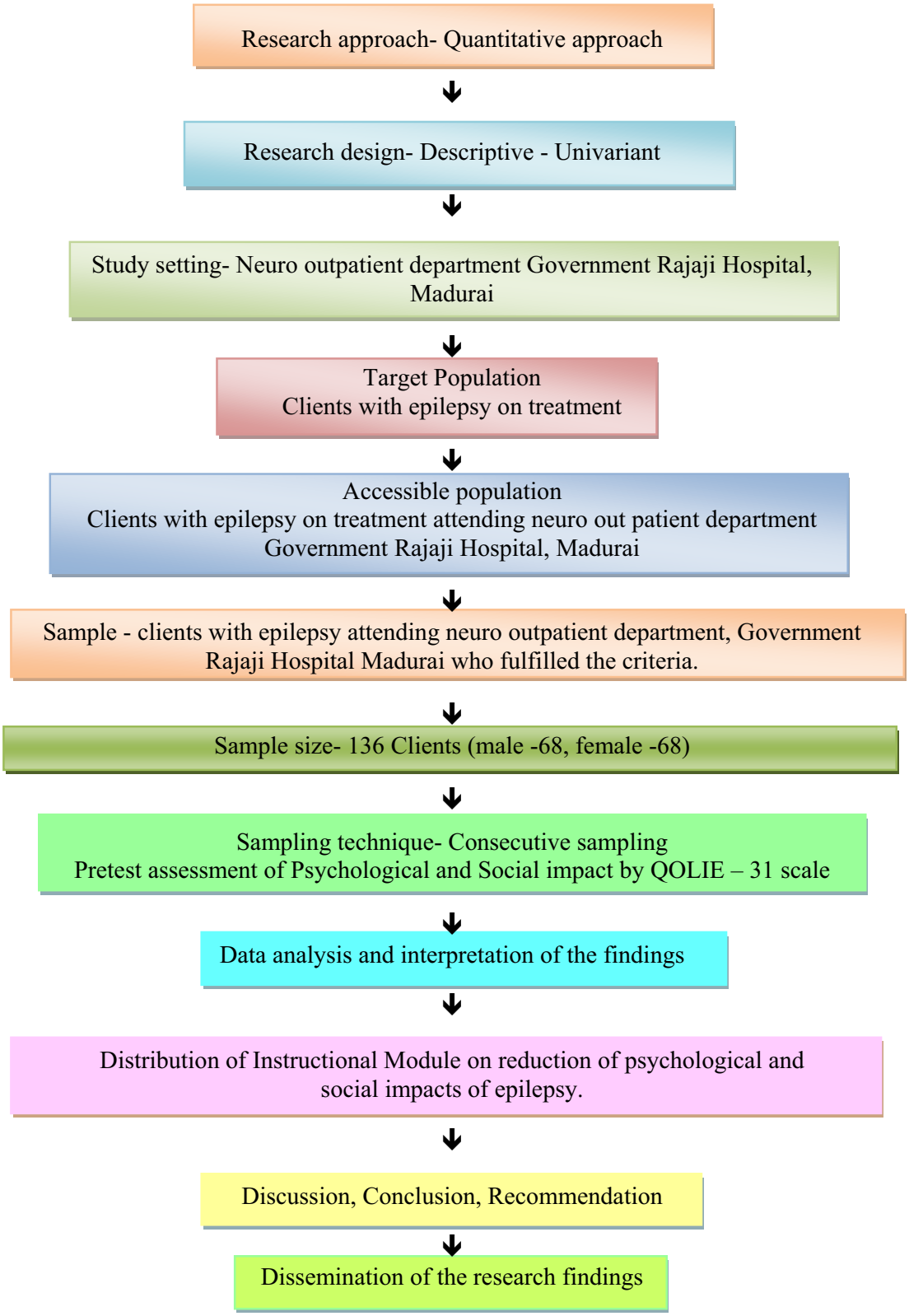
Inferential statistics

One way annova test was used to analyze association between social impacts on epilepsy among epileptic clients with their selected socio demographic variables.

3.18 Protection of human rights

Research proposal was approved by the dissertation committee of College of Nursing, Madurai Medical College, Madurai. Ethical committee approval was obtained from the Institute Ethical Committee, Government Rajaji Hospital, Madurai on 27.01.2015. And also the permission was obtained from the Medical Superintendent and Professor of Neuro medicine. An informed consent from each study sample was obtained before starting the data collection. They were also explained that they may withdraw from the study at any time. Assurance was given to the samples that confidentiality would be maintained through-out the study.

FIGURE - 2 SCHEMATIC REPRESENTATION OF THE STUDY



CHAPTER IV

DATA ANALYSIS

AND

INTERPRETATION

CHAPTER - IV

DATA ANALYSIS AND INTERPRETATION

Analysis is a method of rendering data in quantitative, meaningful and intelligible manger, so that research problem can be studied and tested and the relationship between the variables can be found.

- Polit and hungler, 2006

This chapter deals with analysis and interpretation of data collected from epileptic clients who were attending epileptic neuro outpatient department at Government Rajaji Hospital, Madurai.

Presentation of data

The findings of the study were grouped and analyzed under the following sections:

Section - I: Distribution of socio demographic variables and clinical variables of epileptic clients attending neuro outpatient department at Government Rajaji Hospital, Madurai.

Section – II: Comparison of psychological and social impacts between male and female clients.

Section - III: Association of psychological and social impacts of epilepsy among epileptic clients with their selected socio demographic variables.

Section - I

Distribution of socio demographic variables and clinical variables

Table - 1 Frequency and percentage distribution of samples according to their socio demographic variables n = 136

S.No	Socio Demographic variables	Frequency f	Percentage %
1.	**Age**		
	a. 15 - 25yrs	27	19.90
	b. 26 - 35yrs	36	26.50
	c. 36 - 45yrs	36	26.50
	d. 46 and above	37	27.20
2.	**Gender**		
	a. Male	68	50
	b. Female	68	50
3.	**Religion**		
	a. Hindu	119	87.50
	b. Christian	5	3.70
	c. Muslim	12	8.80
4.	**Education**		
	a. Below 8^{th}std	63	46.30
	b. 9^{th} - 10^{th}std	42	30.90
	c. 11^{th} - 12^{th}std	20	14.70
	d. Degree	11	8.10
5.	**Occupation**		
	a. Cooly	116	85.30
	b. Private	10	7.40
	c. Government	10	7.40
6.	**Monthly income**		
	a. Below Rs.4000	47	34.60
	b. Rs.4000-Rs.6000	58	42.60
	c. Rs.6000-Rs.9000	22	16.20
	d. Above Rs.9000	9	6.60

S.No	Socio Demographic variables	Frequency f	Percentage %
7.	**Marital status**		
	a. Married	136	100
	b. Unmarried	0	0
8.	**Consanguinity**		
	a. Consanguineous	19	14
	b. Non-consanguineous	117	86
9.	**Term at birth**		
	a. Preterm	118	86.80
	b. Normal	8	5.90
	c. Post-term	10	7.40
10.	**Method of delivery**		
	a. Normal	119	87.50
	b. Cesarean	17	12.50
11.	**Residential status**		
	a. Rural	67	49.30
	b. Urban	69	50.70
12.	**Duration of illness**		
	a. Below 3 years	58	42.60
	b. 4 to 7years	26	19.10
	c. Above 7 years	52	38.20
13.	**Duration of treatment**		
	a. Below 3 years	58	42.60
	b. 4 to 7years	26	19.10
	c. Above 7 years	52	38.20
14.	**Birth order**		
	a. First	26	19.10
	b. Second	59	43.40
	c. Third	19	14
	d. Fourth	15	11
	e. Five and above	17	12.50

S.No	Socio Demographic variables	Frequency f	Percentage %
15.	**Food habit**		
	a. Vegetarian	8	5.90
	b. Mixed diet	128	94.10
16.	**Sleeping pattern**		
	a. Below 8hours	87	64
	b. 8hours	49	36
17.	**Commorbidities**		
	a. Epilepsy alone	136	100
18.	**Types of seizures**		
	a. General type	136	100
19.	**Supportive system**		
	a. Husband	45	33.10
	b. Wife	55	40.40
	c. Children	36	26.50

The above tables reveals that, In the aspect of **age** 27(19.9%) subjects belongs in the age group of 15-25years, 36(26.5%) were in the age group of 26-35years and 36-45years respectively, 37 (27.2%) were in the age group of 46 and above.

With respect of **Gender** 68% of the samples were both male and female.

Based on **religion,** 119(87.5%) samples belong to Hindu, 5(3.7%), samples were Christian and 12(8.8%) samples were Muslim.

In the view of **education**63(46.3%) samples had below 8thstd and 42 samples were (30.9%)9thstd to 10thstd, 20 samples were (14.7%)11thstd to 12thstd and11(8.1%) samples were Degree.

Based on**occupation,**116 (85.3%) samples were daily wages, 10(7.4%) samples were working in private company, 10(7.4%) were Government employees.

Regarding **family income** per month47 (34.6%) were below Rs.4000, 58(42.6%) were Rs.4000 - Rs.6000, 22 (16.2%) samples were Rs.6000-Rs.9000, 9(6.6%) were above Rs.9000 respectively.

In respect of **marital status** all clients got married.

With regard of **consanguinity** 19(14%) samples were had the family history of consanguinity, 117(86%) samples had the family history of Non-consanguinity.

With the view in **term at birth,** 118(86.8%) were preterm, 8(5.7%) were normal term, 10(7.4%) were post term.

When viewing **Method of delivery**, 119 (87.5%) were normal delivery, 17 (12.5%) were under went cesarean section.

In the aspect of **residential status** 67(49.3%) samples were residing at rural and 69(50.7%) samples were residing at urban.

In the view of **duration of illness,** 58(42.6%) samples were below 3years, 26(19.1%) samples were 4-7years, 52(38.2%) samples were above 7years respectively.

Based on **duration of treatment** 58(42.6%) samples were below 3years, 26(19.1%) samples were 4-7years, 52(38.2%) samples were above 7years respectively.

In the view of **birth order** 26(19.1%) samples were 1st birth, 59(43.4%) were 2nd birth, 19(14%) were 3rd birth, 15(11%) were 4th birth, 17(12.5%) were five and above.

Based on their **food habits** the study explains 8 (5.9%) samples were vegetarian, 128(94.1%) were mixed diet respectively.

With the view of **sleeping pattern** 87(64%) samples were below 8hours of sleeping and 49(36%) were sleeping 8 hours per day.

Based on **comorbidities** 136(100%) samples were generalized epilepsy only.

In the view of **type of seizures** 136(100%) samples were generalized epilepsy.

In the regard of **supportive system** 45(33.1%) samples were supported by their husbands, 55 (40.4%) samples were supported by their wife's, 36(26.5%) were supported by their children respectively.

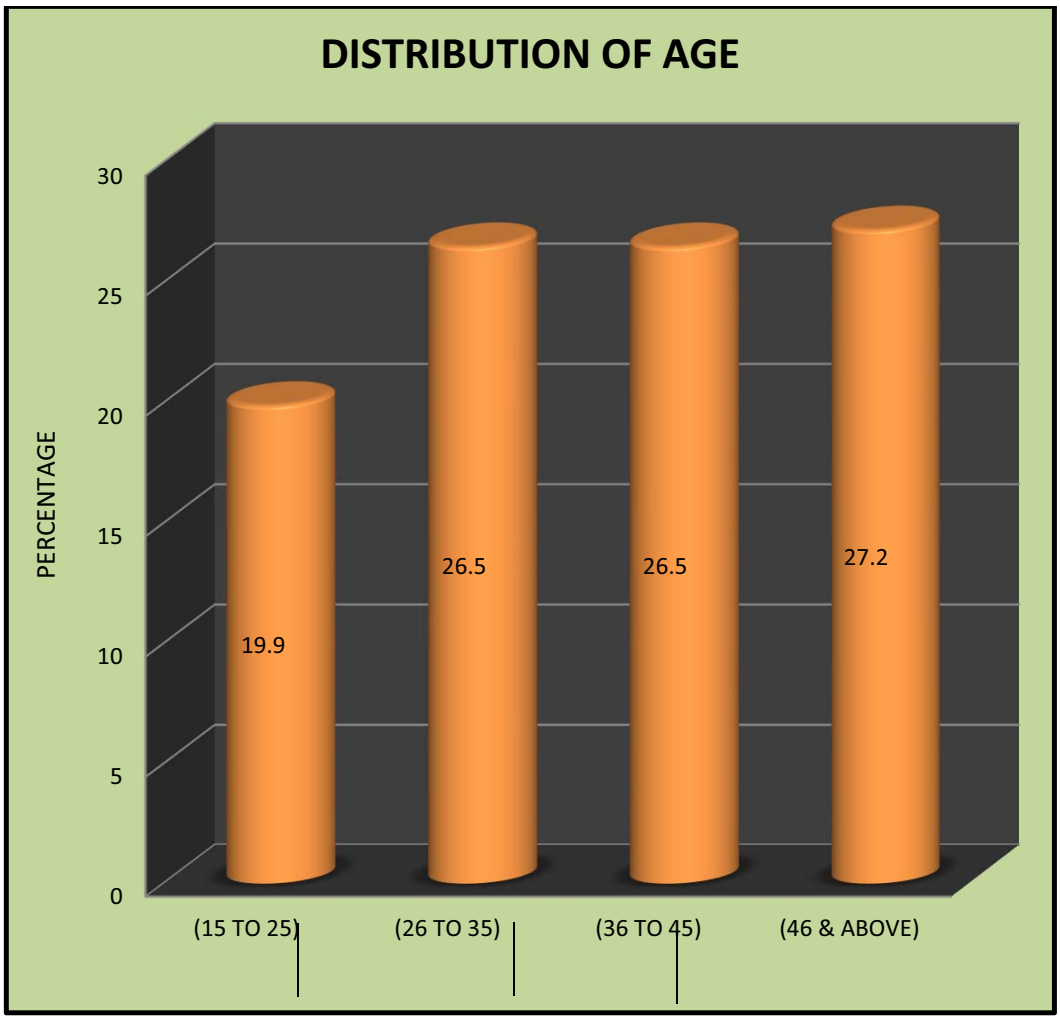


Fig-3. percentage distribution of age among epileptic client

The above cylindrical bar diagram shows that majority of samples 27.2% in the age group of 46 and above.

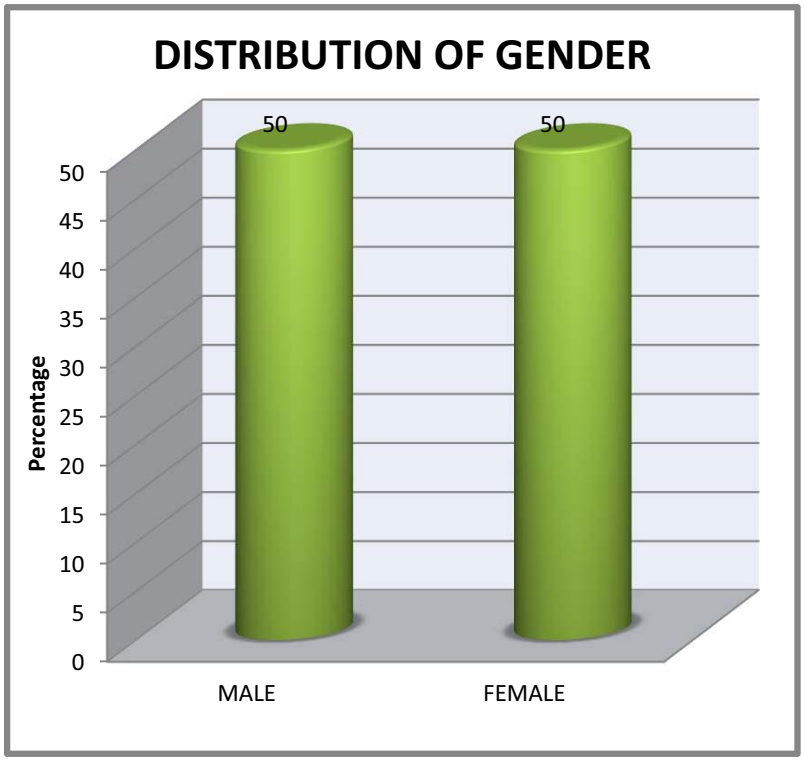


Fig-4. Percentage distribution of gender among epileptic clients

The above cylindrical diagram reveals that 50% of samples were males and females.

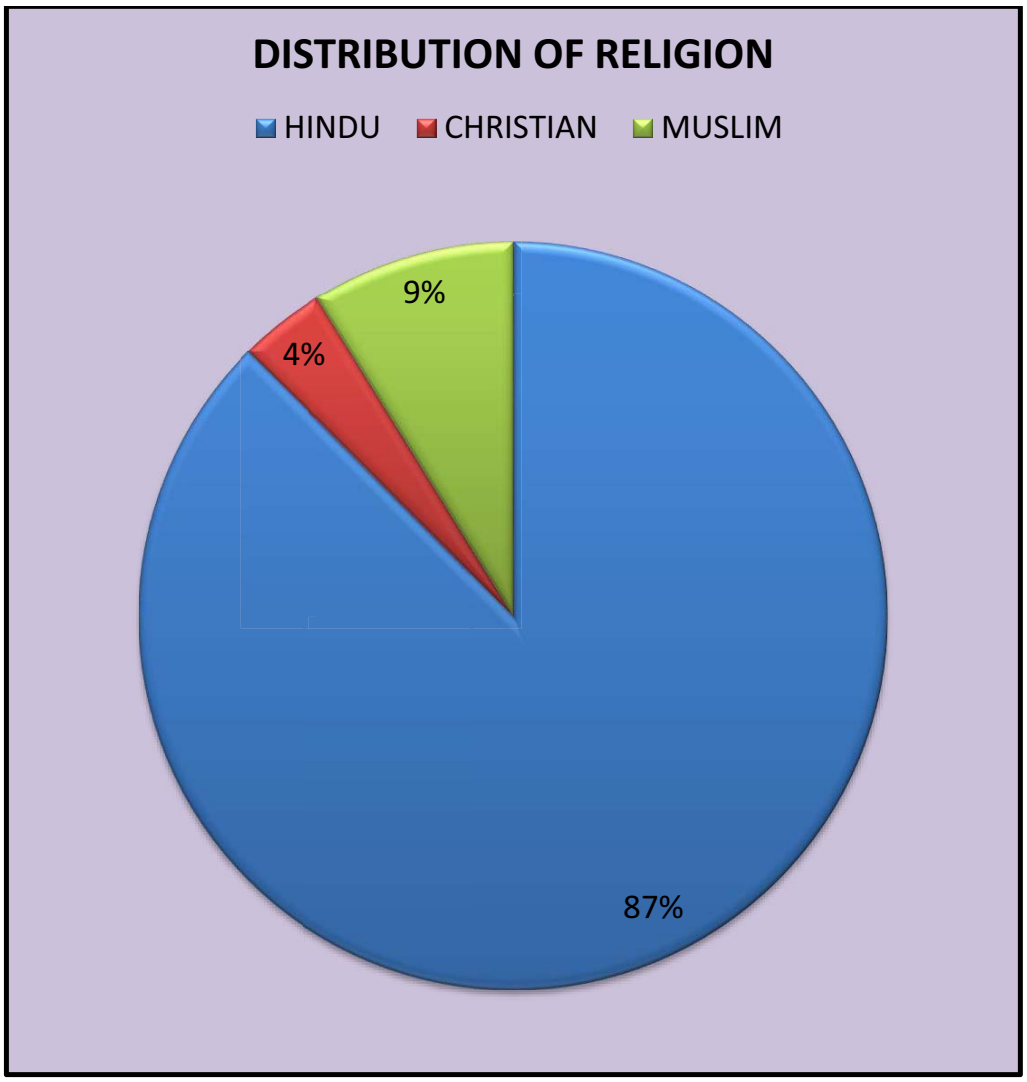


Fig-5. Percentage distribution of religion among epileptic clients

The above pie diagram shows that majority 87% were Hindu, 9% were Muslim, and 4% were Christian.

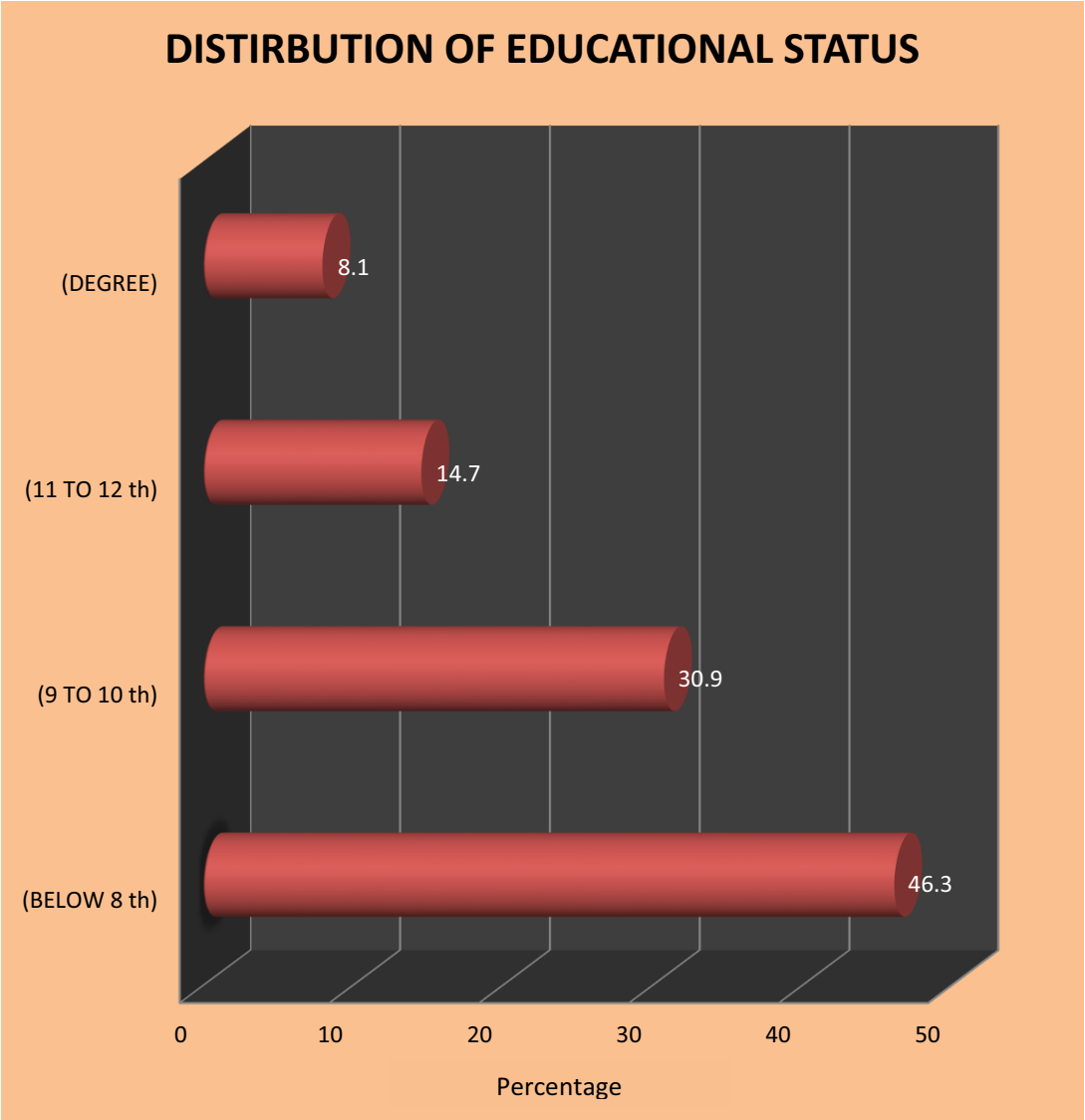


Fig-6. Percentage distribution of educational status among epileptic clients

The above horizontal cylindrical diagram shows that percentage distribution of education ,majority of subjects 46.3% were studied upto8th standard.

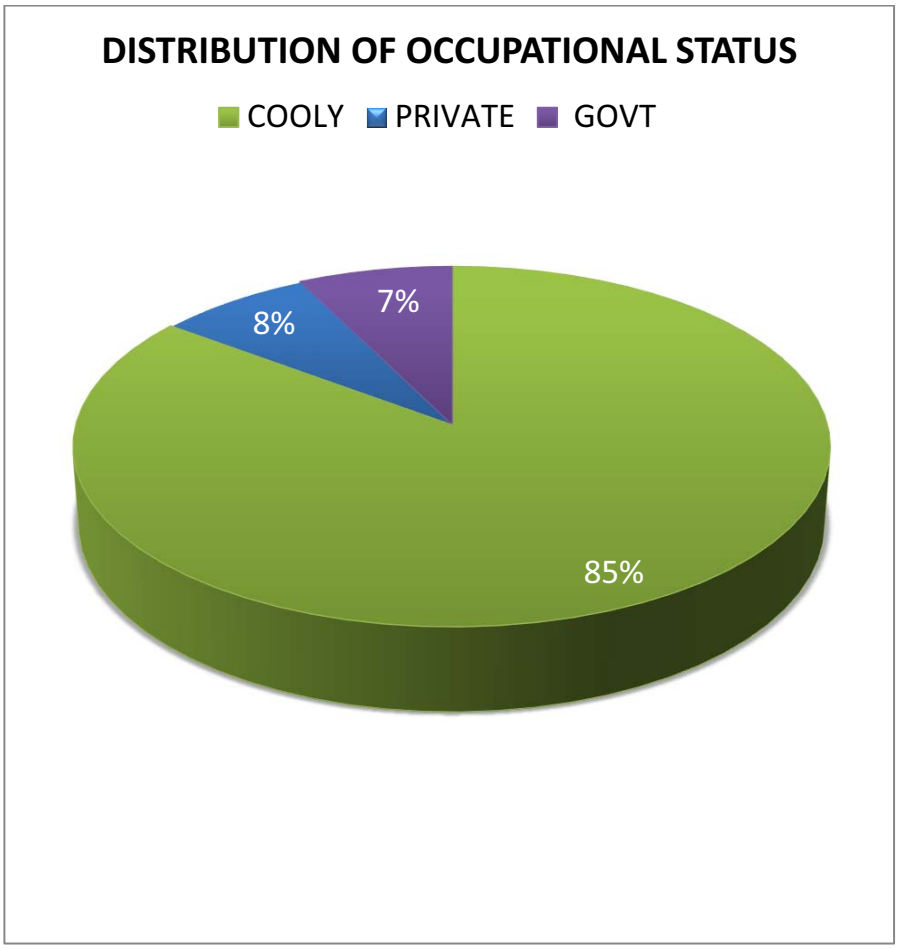


Fig-7. Percentage distribution of occupational status among epileptic clients

The above pie diagram explains that majority of subjects 85% were daily wages.

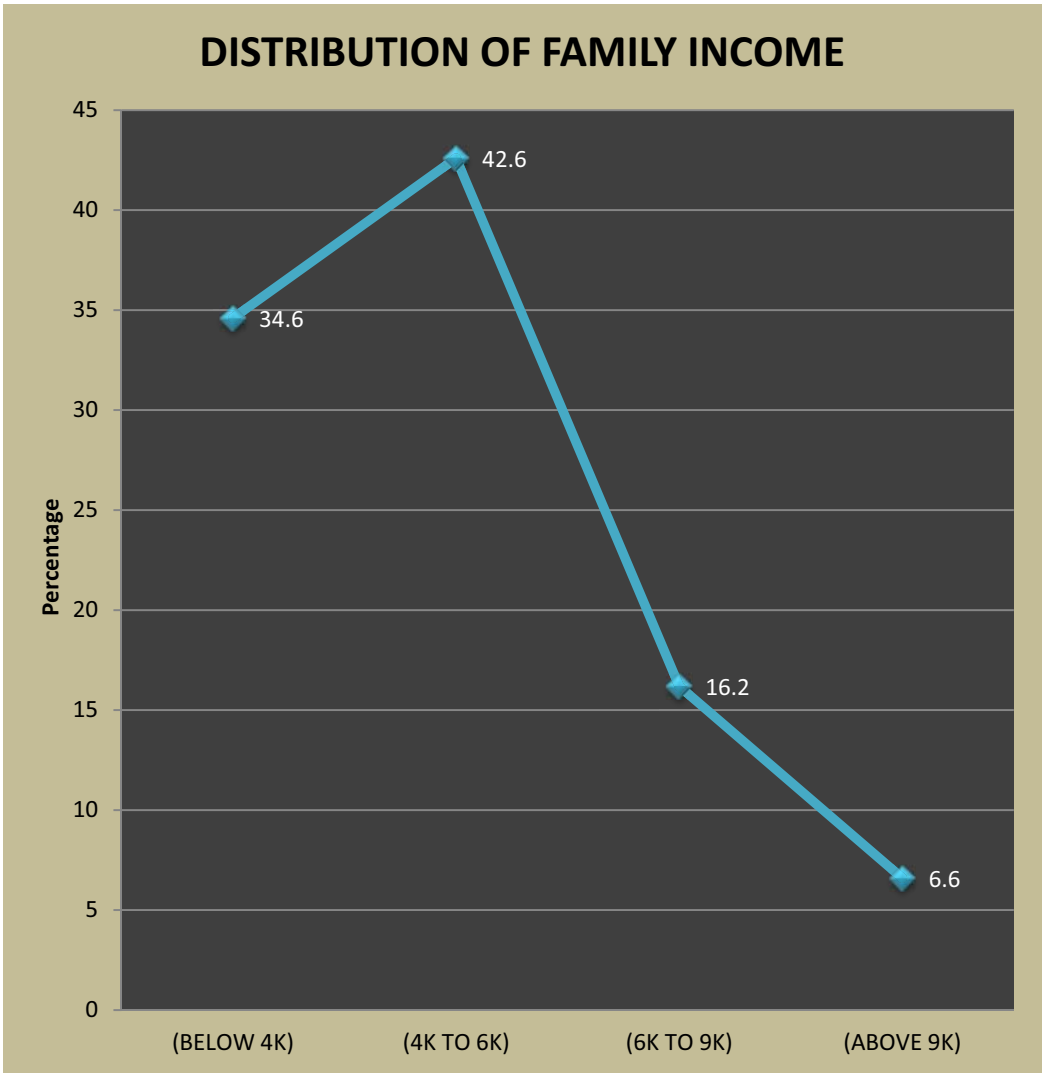


Fig-8. Percentage distribution of family income among epileptic clients

This above frequency polygon diagram shows that percentage distribution of family income of the sample majority of samples 42.6% were between the income of Rs.4000-6000.

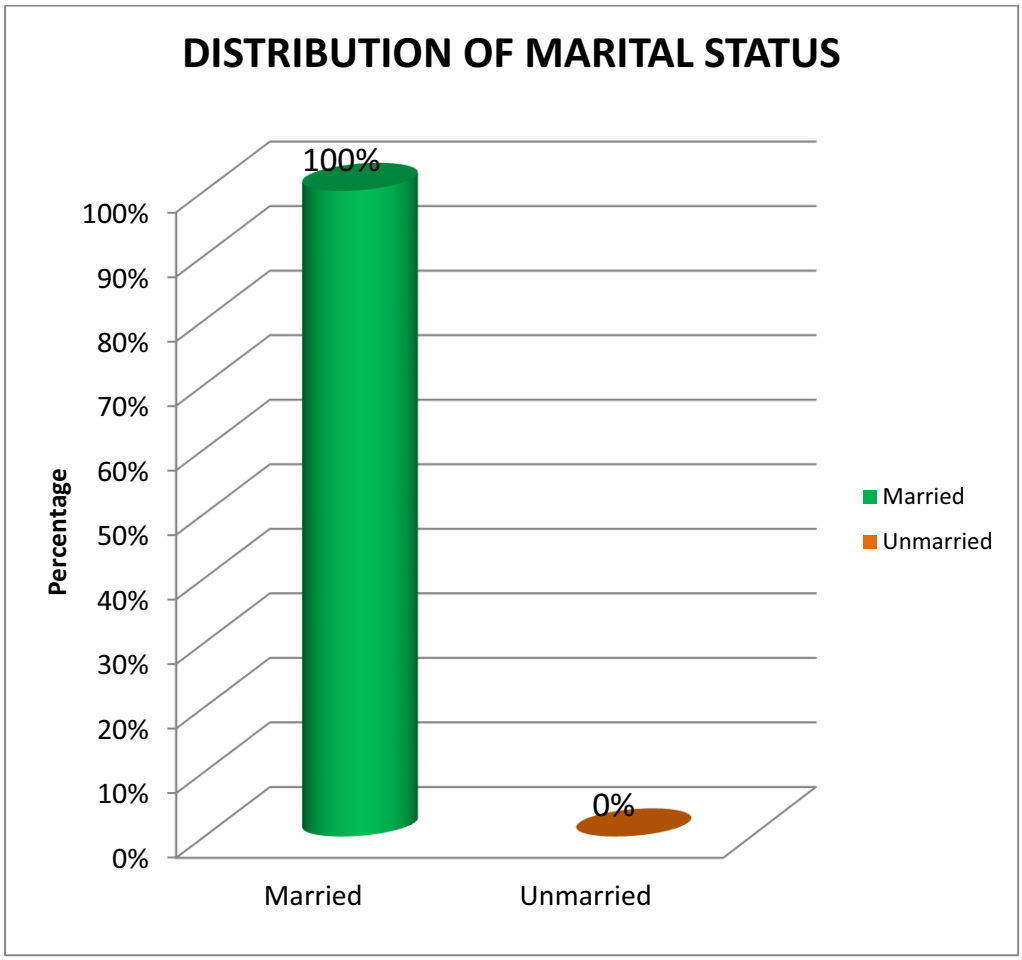


Fig-9. Percentage distribution of marital status among epileptic clients

The above cylindrical diagram shows that majority 100% of subjects were married.

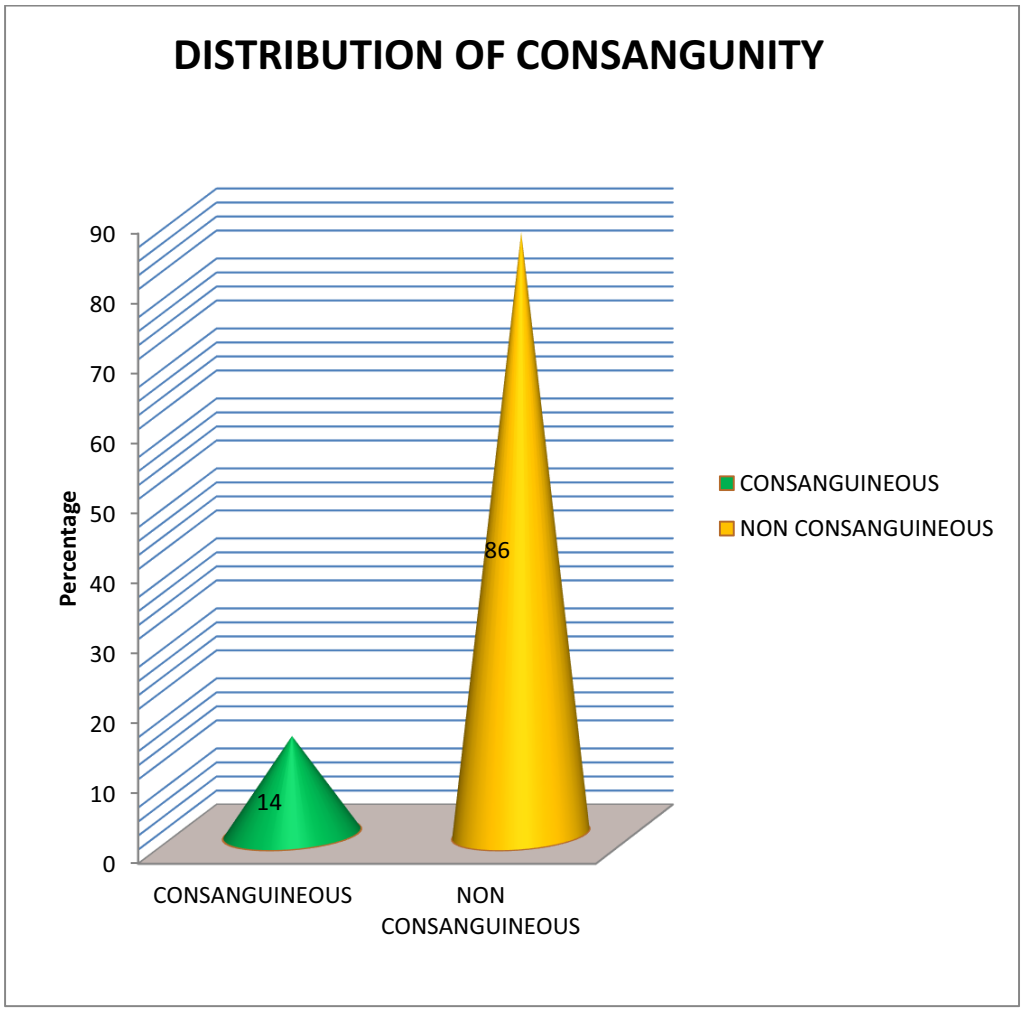


Fig-10. Percentage distribution of consanguinity among epileptic clients

The above cone diagram shows that, majority of the samples (86%) were non consanguineous.

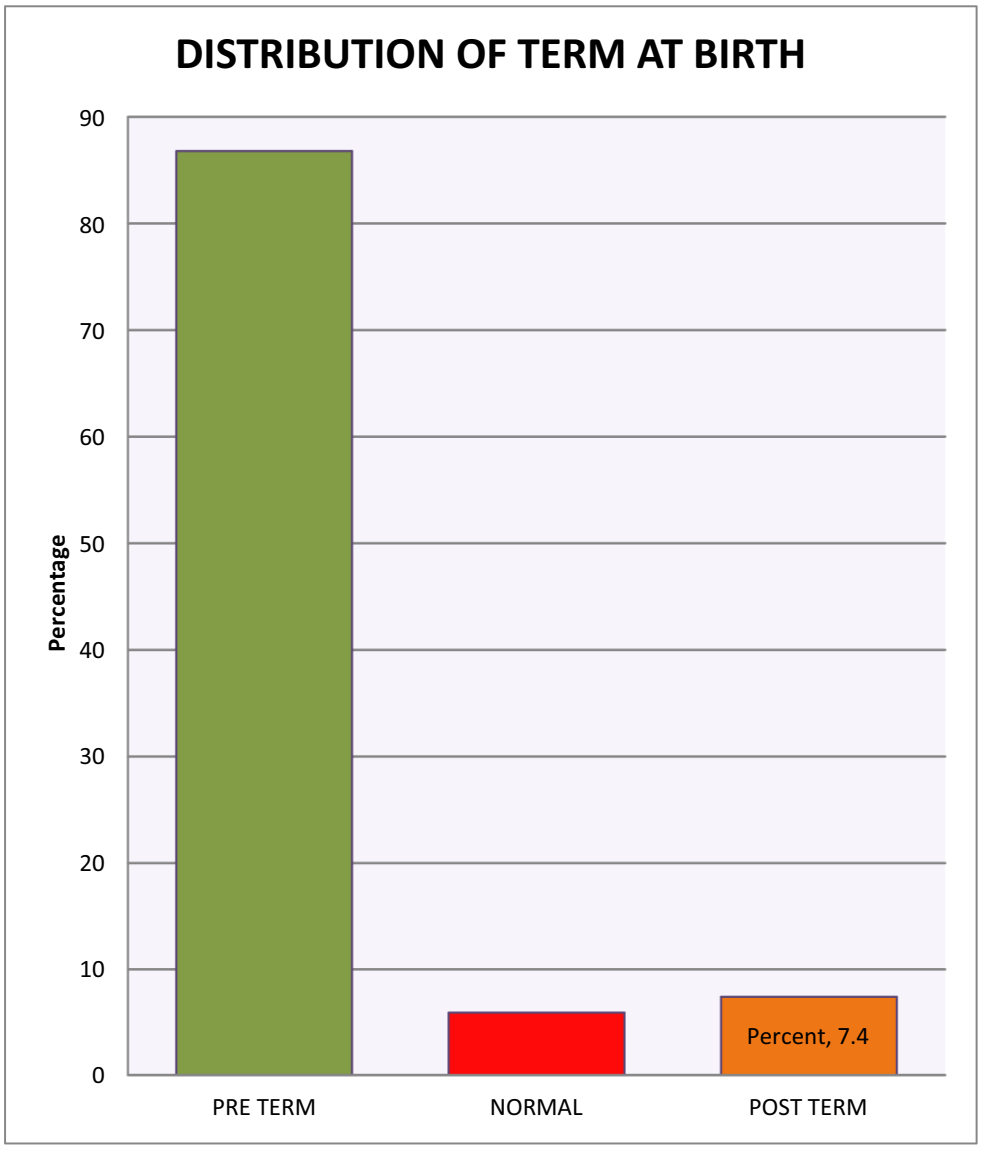


Fig-11. Percentage distribution of term at birth among epileptic clients

This bar diagram shows that, majority of the samples 86.8% were preterm.

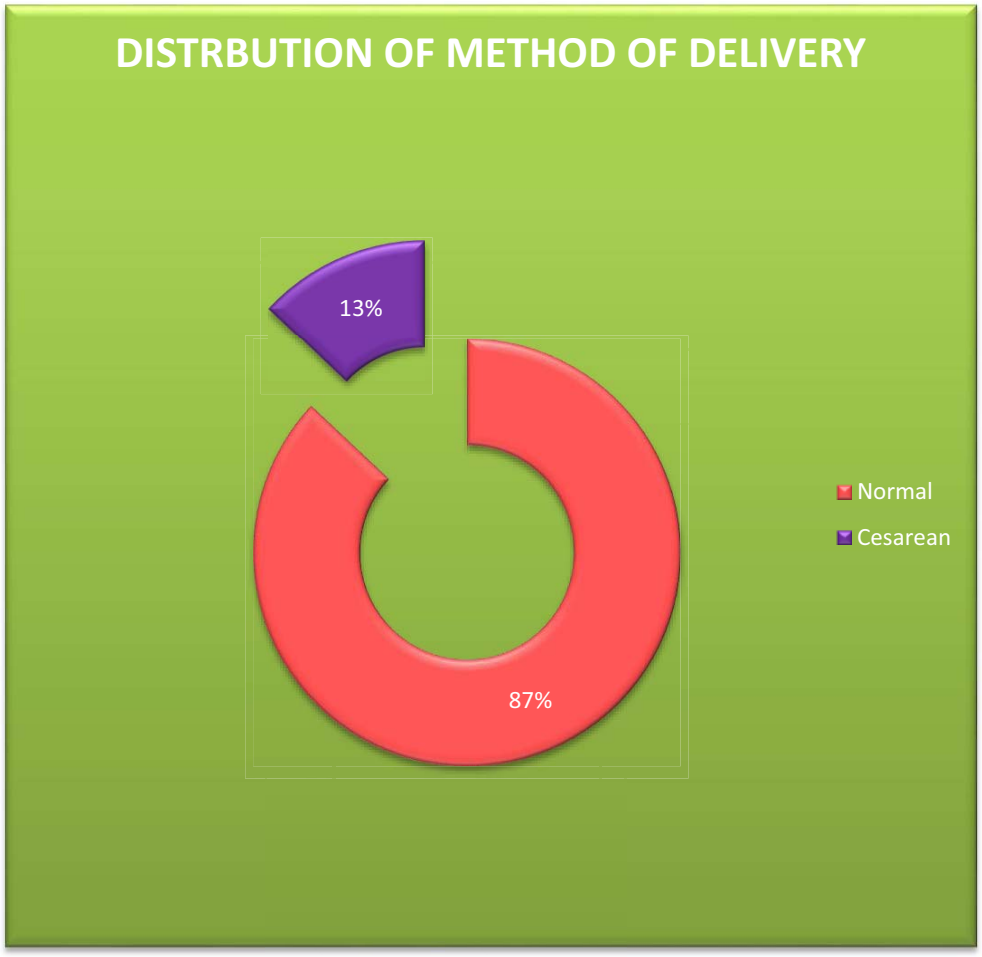


Fig-12. Percentage distribution of method of delivery among epileptic clients

The above doughnut diagram shows that majority of the samples 87% were normal delivery.

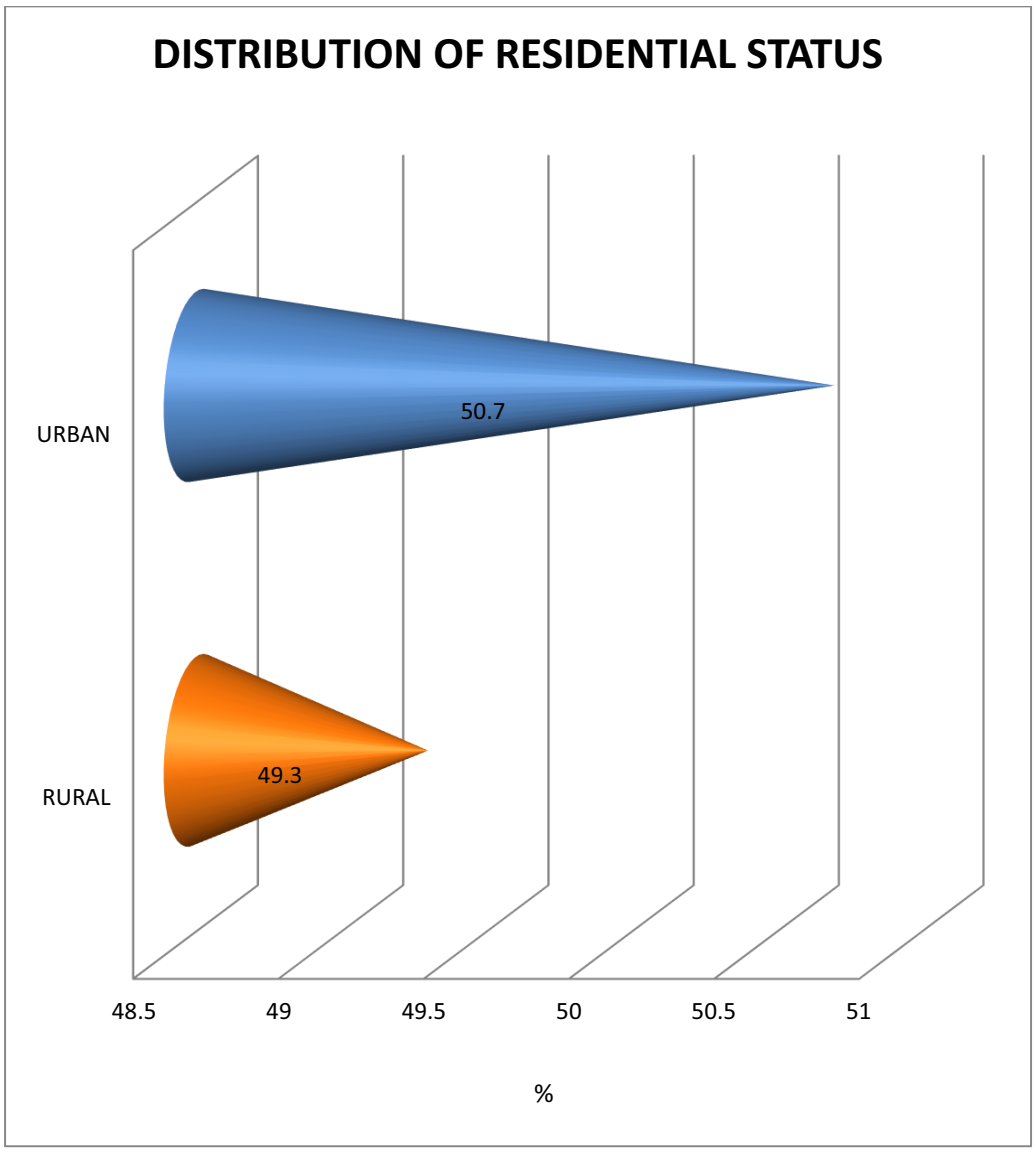


Fig-13. Percentage distribution of residential status among epileptic clients

The above horizontal cone diagram shows that majority of the samples 50.7% were residing in urban area.

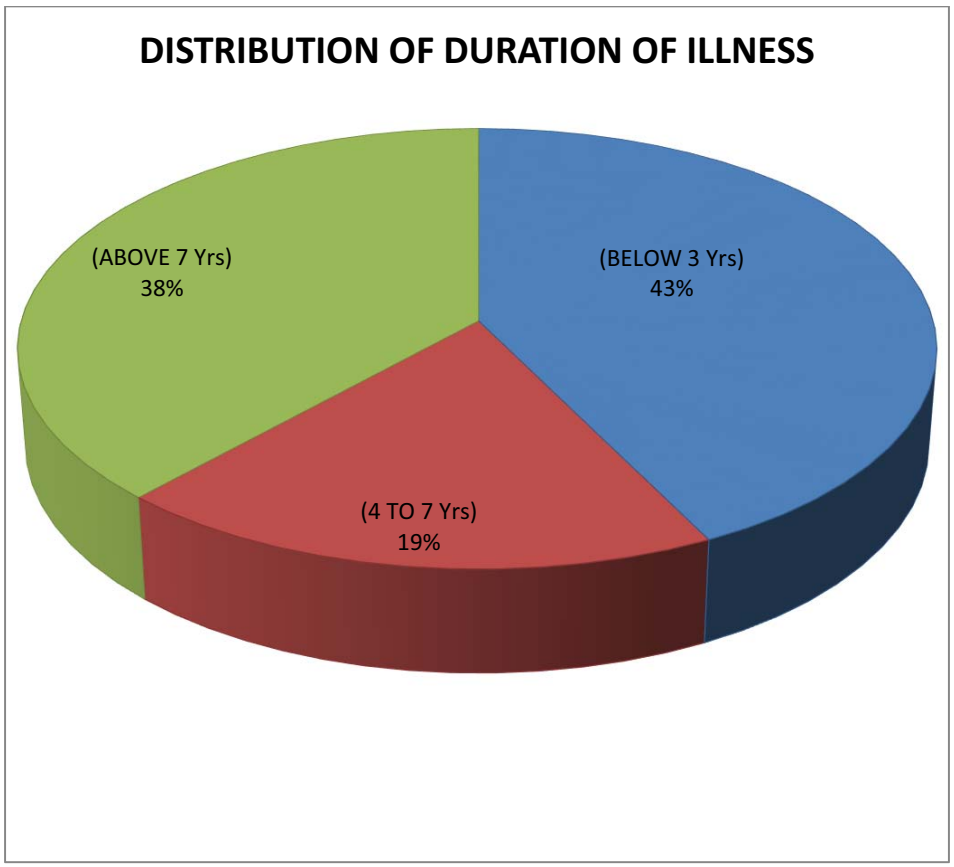


Fig-14. Percentage distribution of duration of illness among epileptic clients

The above pie diagram shows that majority of the samples 43% had below 3years of illness.

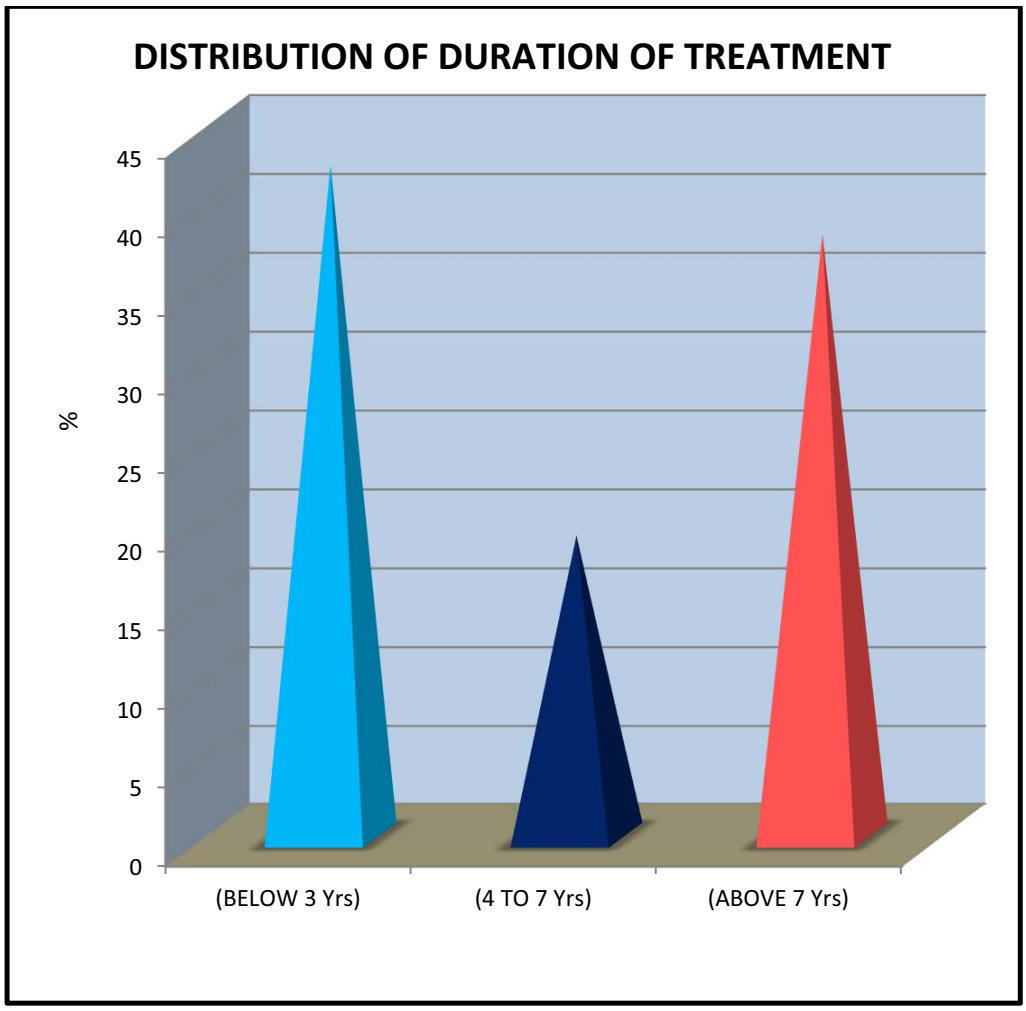


Fig-15. Percentage distribution of duration of treatment among epileptic clients

The above rectangle cone diagram shows that majority of the samples were (42.6%) below 3years of treatment.

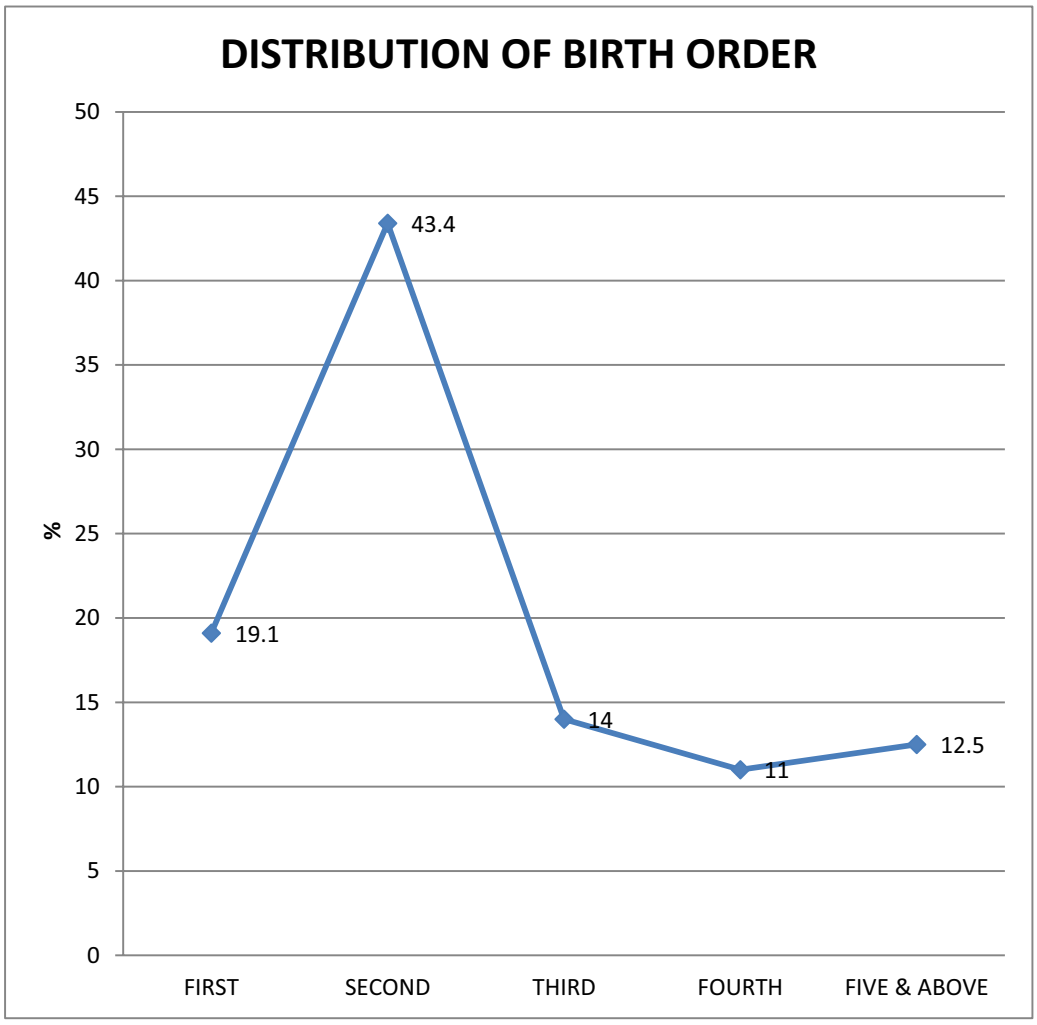


Fig-16. Percentage distribution of birth order among epileptic clients

The above frequency polygon diagram reveals that majority of the samples 43.4% were 2nd birth order.

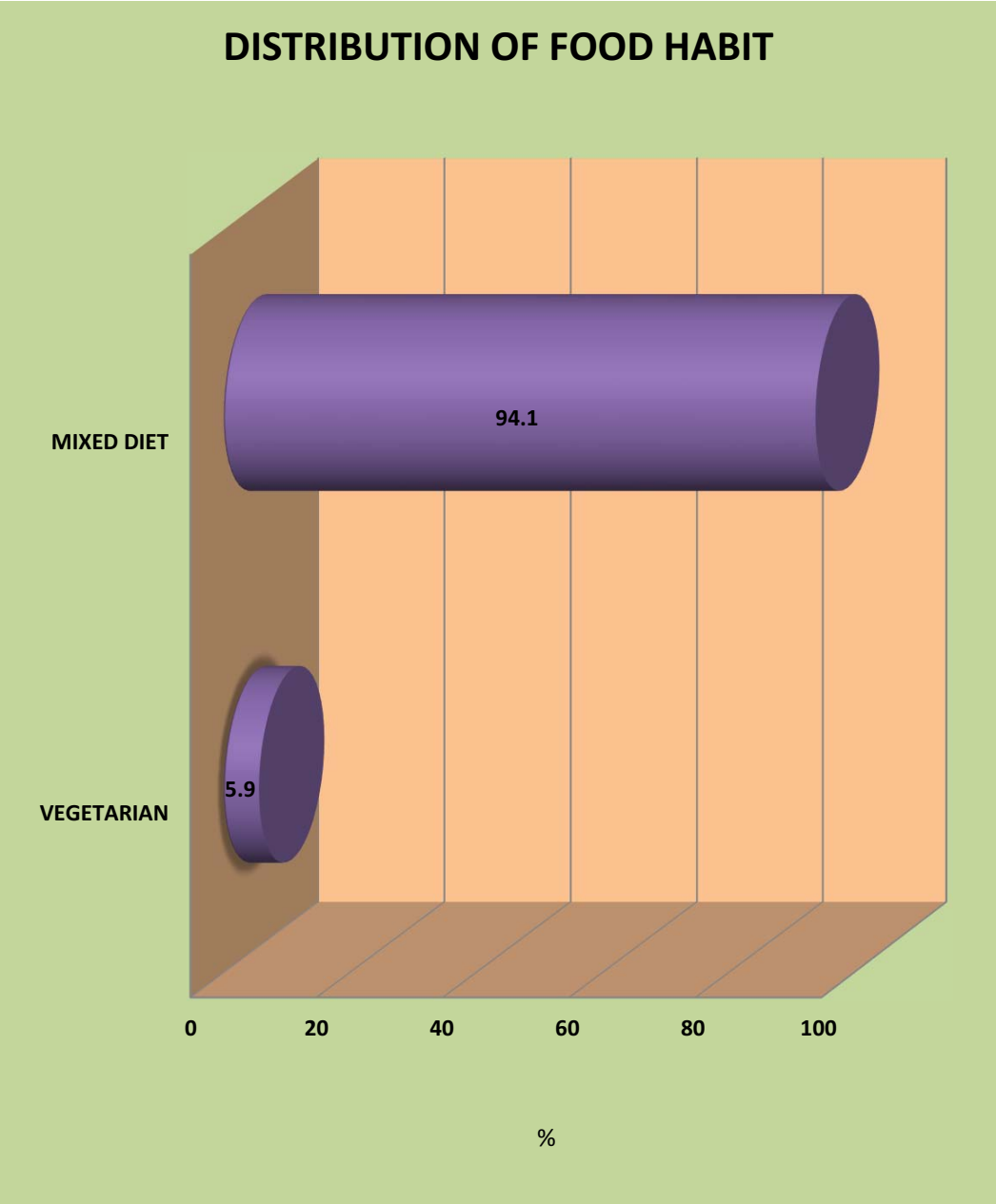


Fig-17. Percentage distribution of food habit among epileptic clients

The horizontal cylindrical diagram shows that majority of the samples (94.1%) were having mixed type of food habits.

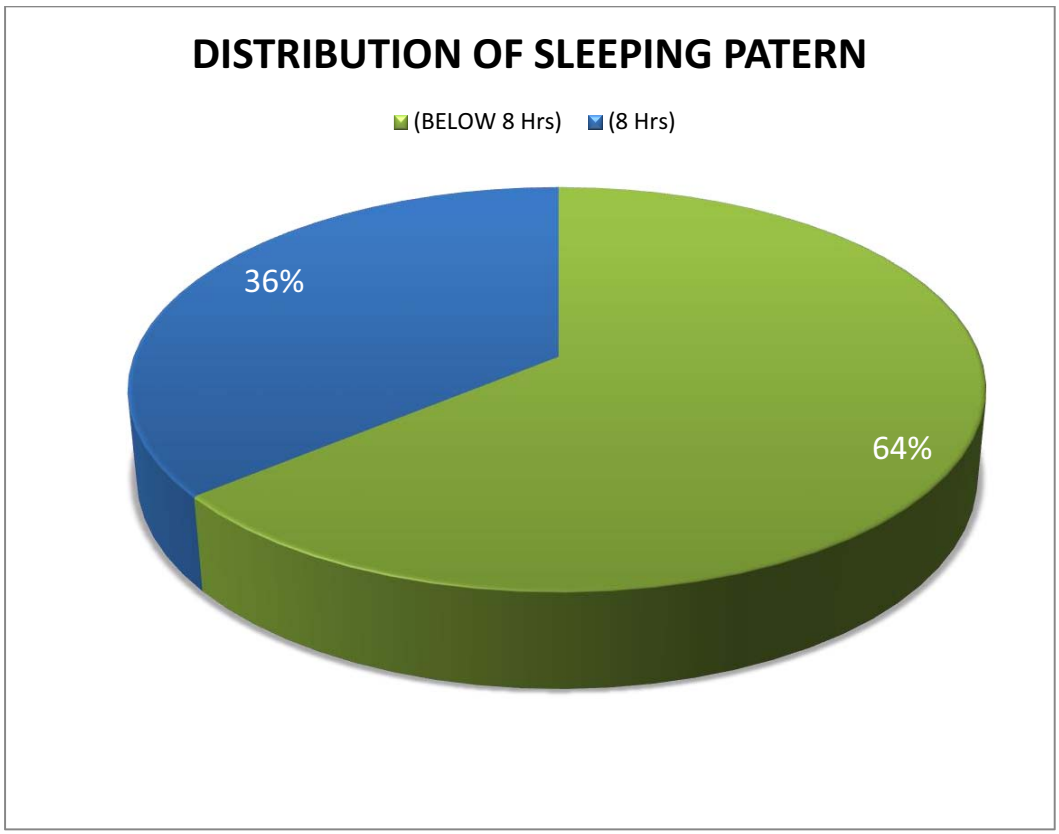


Fig-18. Percentage distribution of sleeping pattern among epileptic clients

The pie diagram shows that majority of the samples 64% were sleeping less than 8 hours per day.

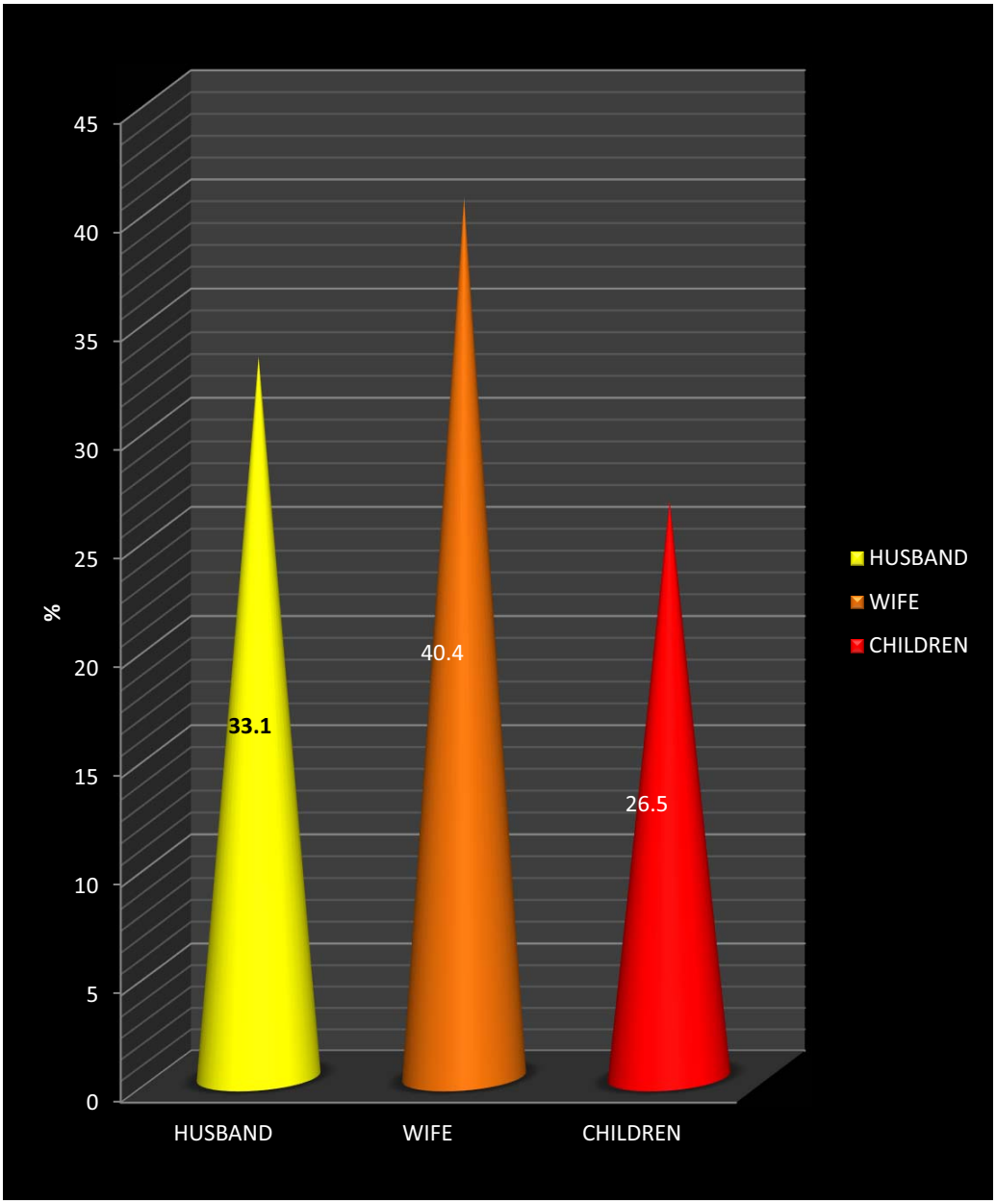


Fig-19. Percentage distribution of support system among epileptic clients

The cone diagram shows that majority of the samples 40.4% were supported by their wives.

Table - 2 Frequency and percentage distribution of clinical variables among epileptic clients. n=136

S.No	Clinical variable	Frequency f	Percentage %
1.	Seizure worry		
	a. Very low	0	0
	b. Low	4	2.9
	c. Moderate	106	77.9
	d. High	25	18.4
	e. Very high	1	0.7
2.	Overall Quality of life		
	a. Very low	0	0
	b. Low	32	23.5
	c. Moderate	103	75.7
	d. High	1	0.7
	e. Very high	0	0
3.	Emotional well being		
	a. Very low	1	0.7
	b. Low	22	16.2
	c. Moderate	113	83.1
	d. High	0	0
	e. Very high	0	0
4.	Energy / Fatigue		
	a. Very low	0	0
	b. Low	23	16.6
	c. Moderate	112	82.4
	d. High	1	0.7
	e. Very high	0	0

S.No	Clinical variable	Frequency (f)	Percentage (%)
5.	Cognitive functions		
	a. Very low	2	1.5
	b. Low	35	25.7
	c. Moderate	99	72.8
	d. High	0	0
	e. Very high	0	0
6.	Medication effects		
	a. Very low	0	0
	b. Low	3	2.2
	c. Moderate	130	95.6
	d. High	3	2.2
	e. Very high	0	0
7.	Social functions		
	a. Very low	0	0
	b. Low	5	3.7
	c. Moderate	129	94.9
	d. High	2	1.5
	e. Very high	0	0
8.	Over all scores		
	a. Very low	0	0
	b. Low	1	0.7
	c. Moderate	135	99.3
	d. High	0	0
	e. Very high	0	0

The above table reveals that with regards of **seizure worry** in the epileptic clients. 4(2.9%) had low worry, 106 (77.9%) had moderate worry and 25(18.4%) had higher worry and 1(0.7%) had very high seizure worry.

With respect of **overall quality of life** in epilepsy clients 32 (23.5%) had low quality of life, 103 (75.7%) had moderate quality of life 1(0.7%) high quality of life.

With the view of **emotional well being** of epilepsy clients 1(0.7%)had very low emotional well being, 22(16.2%) had low emotional well being 113 (83.1%) had moderate emotional well being .

Regarding **fatigue** of epilepsy clients 23(16.6%)had low energy fatigue, 112 (82.4%) had moderate energy fatigue, and 1(0.7%) had unique energy.

With the view of **cognitive functions** of epilepsy clients 2(1.5%) had very low level 35(25.7%) had low level, 99 (72.8%) were having moderate level of cognitive functioning.

With the respect **social functions of epilepsy** clients 5(3.7%) had low level, 129 (94.9%) had moderate level and 2(1.5%) had high level of social function.

From this study **overall score** of social impacts of epileptic clients 1(0.7%) had low level and 135(99.3%) had moderate level score.

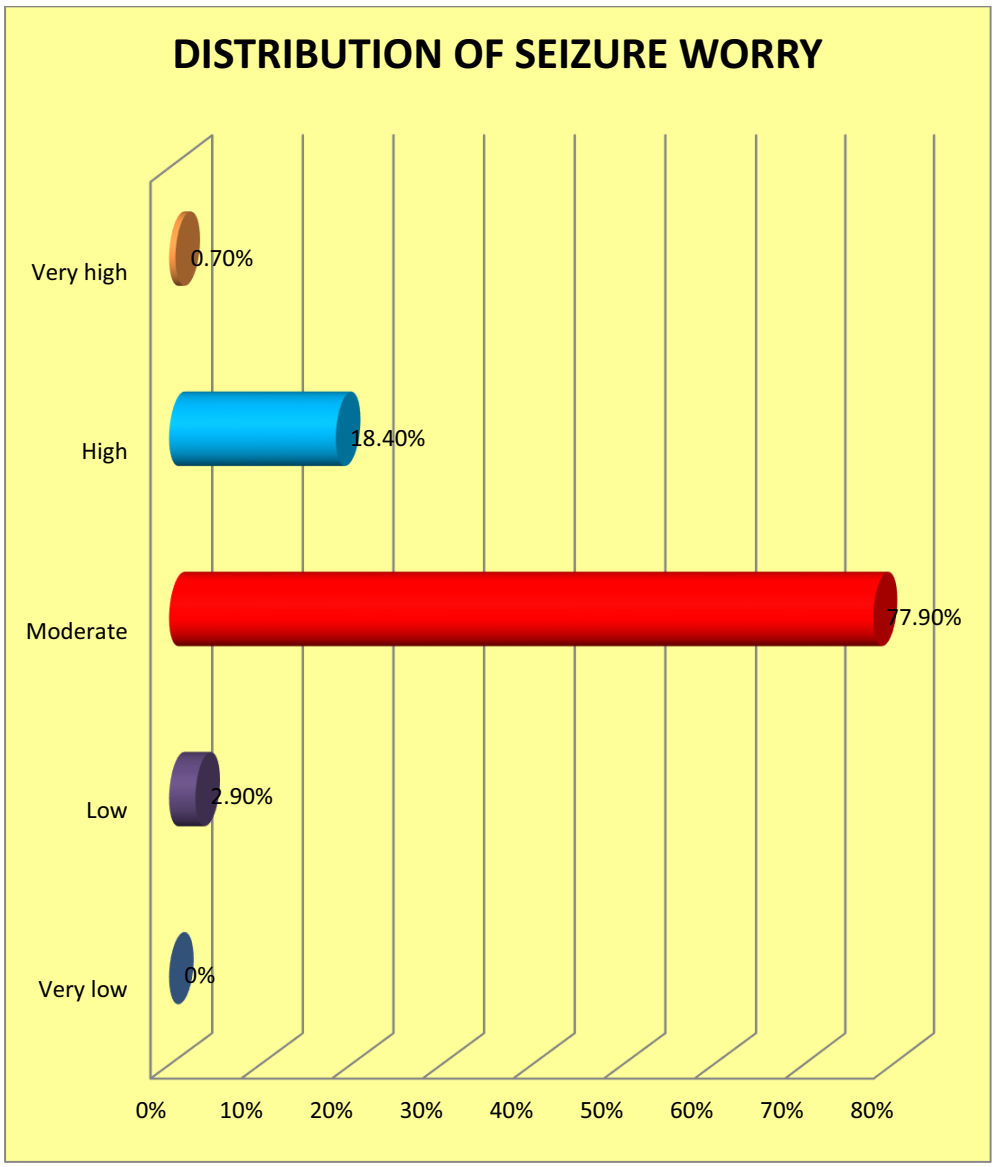


Fig- 20. percentage distribution of seizure worry

The above horizontal cylindrical bar diagram reveals that majority of the samples (77.9%) were moderate worry.

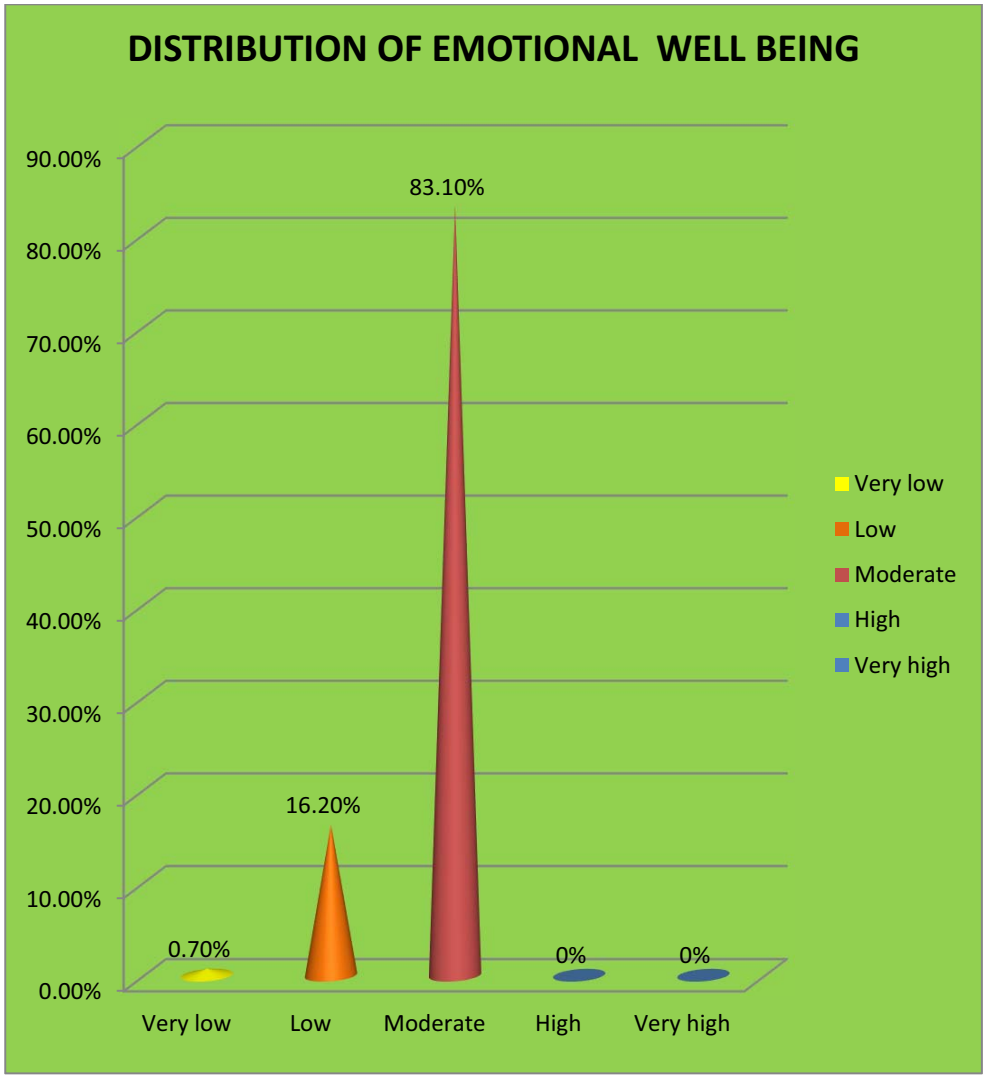


Fig-21. Percentage distribution of emotional well being

The above cone diagram shows that the majority of samples (83.10%) were moderate of emotional well being.

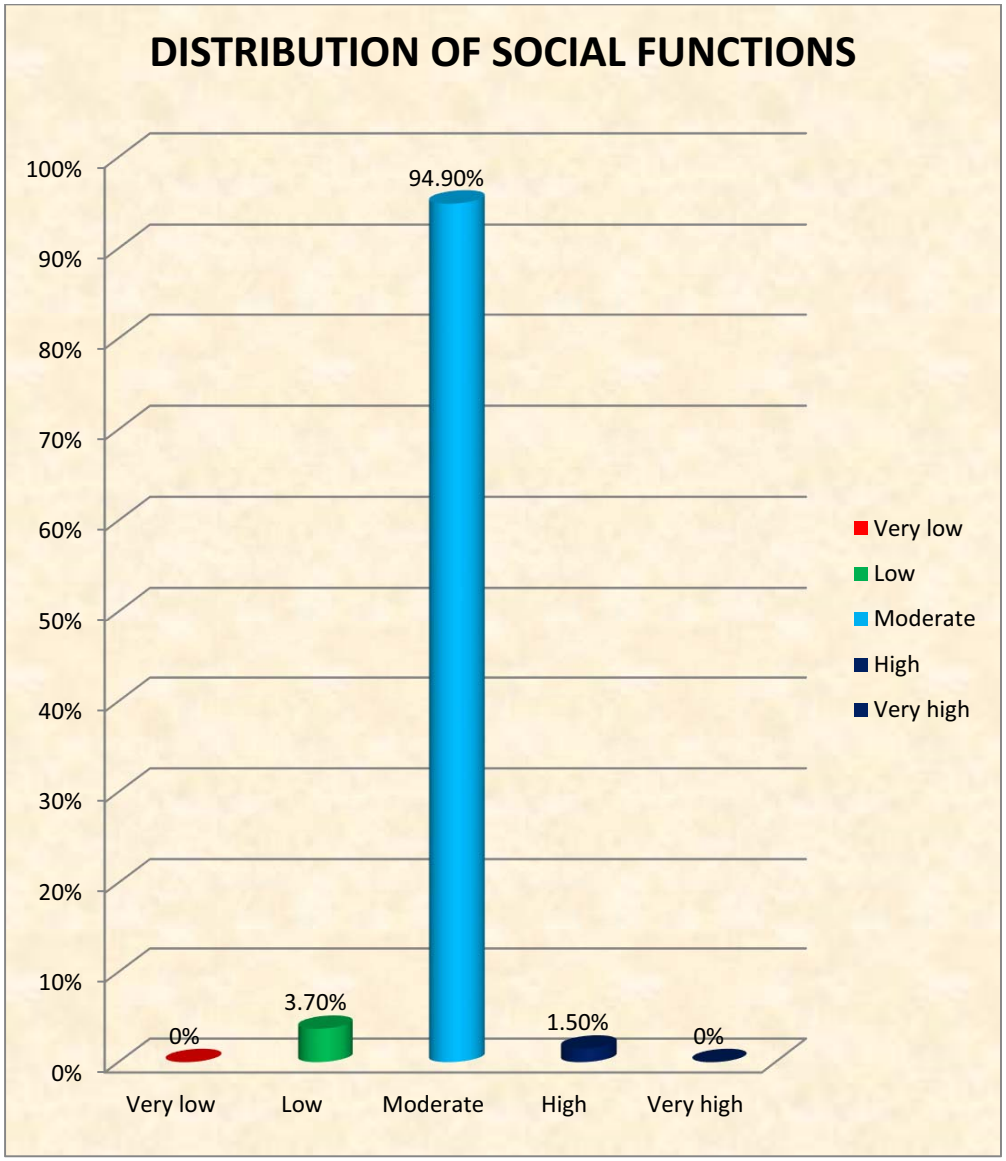


Fig-22. Percentage distribution of social functions

The above cylindrical bar diagram explains that the majority of the samples (94.90%) were moderate of social functions.

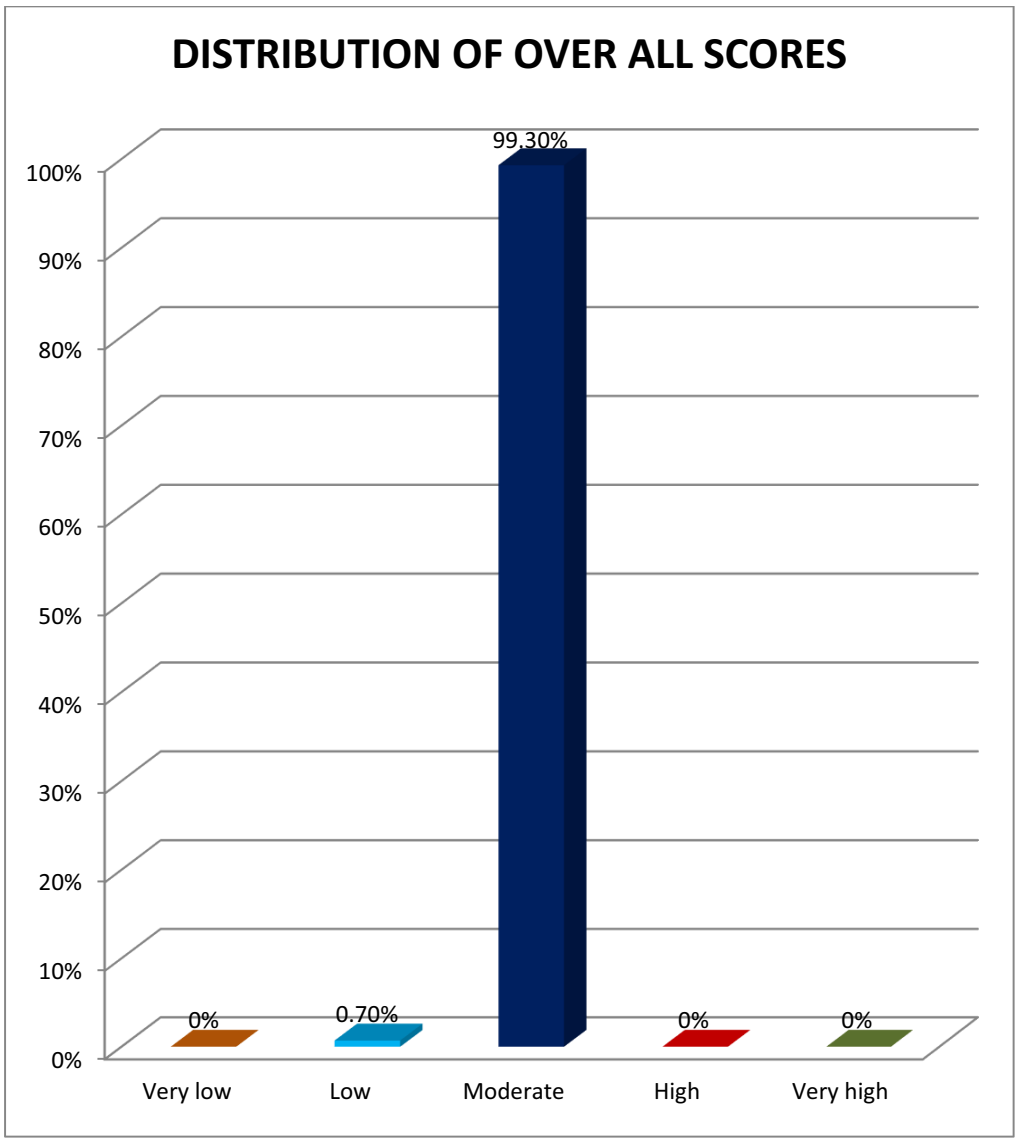


Fig-23. Percentage distribution of overall scores

The above bar diagram reveals that the majority of the samples (99.30%) were moderate of overall scores.

SECTION – II

Comparison of psychological and social impacts between male and female clients.

Table - 3 Comparison of psychological and social impacts of epilepsy between male and females in Clinical Variables

n=136 (Male = 68, Female = 68)

S. No	Clinical variable	Very Low	Low	Moderate	High	Very high	Chi-square	df	
1.	**Seizure worry**								
	a. Male		2(1.47%)	52(38.24%)	13(9.56%)	1	1.398	3	0.706 N.S
	b. Female		2(1.47%)	54(39.71%)	11(8.09%)	(0.74%)			
2.	**Overall Quality of life**								
	a. Male	-	18(13.24%)	49(36.03%)	1(0.74%)		1.010	2	0.604 N.S
	b. Female	-	16(11.76%)	52(38.24%)		-			
3.	**Emotional well being**								
	a. Male	-	13(9.56%)	55(40.44%)	-	-		2	0.405 N.S
	b. Female	1(0.74%)	9(6.62%)	58(42.65%)	-	-	1.807		
4.	**Fatigue**								
	a. Male	-	13(9.56%)	55(40.44%)	-	-	1.427	2	0.490 N.S
	b. Female	-	10(7.35%)	57(41.91%)	1(0.74%)	-			
5.	**Cognitive functions**								
	a. Male	1 (0.74%)	15(11.03%)	52(38.24%)	-	-	0.967	2	0.617 N.S
	b. Female	1(0.74%)	20(14.71%)	47(34.56%)	-	-			
6	**Medication effects**								
	a. Male	-	1(0.74%)	65(47.79)	2(1.47%)	-	0.667	2	0.717 N.S
	b. Female	-	2(1.47%)	65(47.79%)	1(0.74%)	-			
7	**Social functions**								
	a. Male	4(2.94%)	3(2.21%)	59(43.38%)	2(1.47%)	-	1.706	2	0.396 NS
	b. Female	4(2.94%)	1(0.74%)	62(45.58%)	1(0.74%)	-			
8	**Over all scores**								
	a. Male		-	68(50%)	-	-	1.321	2	0.197 NS
	b. Female		1(0.74%)	67(49.26%)	-	-			

The above table reveals that with requests of **seizures worry** in males 2(1.47%) had low impact of seizure worry, 52(38.24%) had moderate worry and

13(9.56%) here had high impact of seizure worry and 1(0.74%) had very high impact of seizure worry in female 2(1.47%) were had low seizure worry, 54(39.71%) were had moderate seizure worry, 11 (8.09%) were had high seizure worry.

With the respects of **overall quality of life**, in males 18(13.24%) were had low quality of life, 49(36.03%) were had moderate quality of life, 1(0.74%) have high quality of life. In female 16 (11.76%) were had low quality of life, 52 (38.24%) were had moderate quality of life.

With the view of **emotional well being** in males 13(9.56%) were had low emotional well being, 55(40.44%) were had high emotional well being. In female 1(0.74%) had very low emotional well beings, 9(6.62%) were had low, and 58 (42.65%) were had high emotional well being.

With the regards of **fatigue,** in males 13(9.56%) were had low energy/ fatigue, 55(40.44%) were had moderate energy/ fatigue. In female 10(7.35%) were had low energy/ fatigue, 57 (41.91%) were had and 1 (0.74%) had high energy/ fatigue.

When compare with **cognitive function** in male 1(0.74%) were had very low cognitive function, 15(11.03%) were had low cognitive function, and 52(38.24%) were had moderate cognitive function. In female 1 (0.74%) had very low cognitive function, 20(14.71%) were had low cognitive function, 47 (34.56%) were had moderate cognitive function impacts.

When the worry of **medication effects** in males 1(0.74%) had low worry, 65 (47.29%) were had moderate worry, and 2(1.47%) were had high worry. In female 2(1.47%) were had low worry, 65 (47.79%) were had moderate worry, and 1(0.74%) had high worry.

With the view of **social function,** in males 5(3.68%) were had very low social function, 4(2.94%) were had low social function, 59 (43.38%) were had moderate

social function. In female, 4(2.94%) were had very low social function, 2(1.47%) were had low social function, 62(45.58%) were moderate social function.

With the respects of **overall score** in male 68(50%) were had moderate score. In female 1(0.74%) had low score, 67 (49.26%) were had moderate scores.

SECTION – II

Comparision of Psychological and social impacts between male and female epileptic clients

Table - 4 Mean and Standard Deviation for Psychological and Social Impacts among Male and Female Clients

S.No	Clinical variable	n	Mean	SD	Mean difference	't' value
1.	Seizure worry					
	a. Male	68	56.30	6.22	5.65	5.67
	b. Female	68	61.95	5.58		
2.	Overall Quality of life					4.74
	a. Male	68	47.46	4.10	3.38	
	b. Female	68	44.08	4.20		
3.	Emotional well being					
	a. Male	68	46.23	3.54	9.48	20.82
	b. Female	68	55.70	1.21		
4.	Fatigue					
	a. Male	68	47.94	4.40	17.71	31.02
	b. Female	68	65.64	1.66		
5.	Cognitive functions					
	c. Male	68	58.21	3.84	15.07	15.44
	d. Female	68	43.14	7.07		
6.	Medication effects					
	a. Male	68	69.54	6.31	14.51	16.03
	b. Female	68	55.02	3.99		
7.	Social functions					
	a. Male	68	54.91	8.93	5.62	6.12
	b. Female	68	49.29	5.03		
8.	Over all scores					
	a. Male	68	52.74	3.76	3.97	6.89
	b. Female	68	48.78	2.88		

P <.000 level of significant

With the view of psychological and social impacts of **seizure worry** of epilepsy clients. Mean and standard deviation male and female was 56.30, 61.95, 6.22, 5.58 respectively mean difference was 5.65. The test of significance was calculated using 't' value is 5.67 at P <.000 level of significance.

With the respect of **overall quality of life** of epilepsy clients. The mean and standard deviation of male and female was 47.46, 44.08, 4.10, and 4.20 respectively. The mean difference was 3.38. The test was significance was calculated using 't' value is 4.74 at P <.000 level of significance.

With the view of psychological and social impacts of **emotional well being** of the epilepsy clients. The mean and standard deviation of male and female was 46.23, 55.70, 3.54 and 1.21 respectively. The mean difference was 9.48. The test of significance was calculated using 't' value is 20.82 at P <.000 level of significance.

Regarding psychological and social impacts of **fatigue** of the epilepsy clients. The mean and standard deviation of male and female was 47.94, 65.64, 4.40 and 1.66 were respectively. The mean difference was 17.71.The test of significant calculated using 't' value is 31.02 at P < .000 level of significance.

With the respect of psychological and social impacts of **cognitive functioning** of the epilepsy clients. The mean and SD of male and female was 58.21, 43.14,3.84 and 7.07 respectively. The mean difference was 15.07. The test of significance was calculated using 't' value is 15.44 at P<.000 level of significance.

Based on psychological and social impacts of **medication effects** of the epilepsy clients. The mean and SD of male and female was 69.54, 55.02, 6.31 and 3.99 respectively. The mean difference was 14.51. The test of significance was calculated using't' value is 16.03 at P<.000 which level of significance.

In the aspect of psychological and social impacts of **social functions** of the epilepsy clients. The mean and SD of male and female was 54.91, 49.29, 8.93 and 5.03 respectively. The mean difference was 5.62. The test was significance was calculated using ‘t’ value is 6.12 at P<.000 which level of significance.

With regards of psychological and social impacts of **overall total score** of epilepsy clients. The mean and SD of male and female was 52.74, 48.78, 3.76 and 2.88 respectively. The mean difference was 3.97. The test of significance was calculated using‘t’ value is 6.89 at P<.000 level of significance.

Section -III

Association of psychological and social impacts of epilepsy among epileptic clients with their selected socio demographic variables.

Table -5 Association between Psychological and social impacts among epilepsy with their socio demographic variables n=136

S.No	Demographic variables	f	Mean	SD	One way Annova/ F Test
1.	Age				
	a. 15 - 25yrs	27	48.25	2.09	**F=21.681**
	b. 26 - 35yrs	36	48.31	3.35	**P < .000***
	c. 36 - 45yrs	36	46.76	3.01	**Significant**
	d. 46 and above	37	43.25	3.27	
2.	Religion				F = 1.569
	a. Hindu	119	46.34	3.71	P = .212
	b. Christian	5	46.31	4.40	Not
	c. Muslim	12	48.29	2.24	significant
3.	Education				
	a. Below 8^{th}std	63	48.93	2.95	**F = 21.681**
	b. 9^{th} - 10^{th}std	42	48.42	2.42	**P = <.000***
	c. 11^{th} - 12^{th}std	20	51.19	1.53	**Significant**
	d. Degree	11	53.58	8.51	
4.	Occupation				**F=116.326**
	a. Cooly	116	46.68	3.98	**P = <.000***
	b. Private	10	54.14	5.53	**Significant**
	c. Government	10	67.50	6.35	
5.	Monthly income				
	a. Below Rs.4000	47	49.56	4.35	**F= <1.694**
	b. Rs.4000-Rs.6000	58	49.45	2.28	**P = <.000***
	c. Rs.6000-Rs.9000	22	49.73	1.93	**Significant**
	d. Above Rs.9000	9	60.23	9.40	

S.No	Demographic variables	f	Mean	SD	One way Annova/ F Test
6.	Consanguinity				F =2.796
	a. Consanguineous	19	50.69	7.88	P = <.006
	b. Non-consanguineous	117	56.69	8.81	Not significant
7.	Term at birth				F = 14.535
	a. Preterm	118	53.13	10.19	P = <.000
	b. Normal	8	71.00	0.93	Not
	c. Post term	10	61.00	8.96	significant
8.	Delivery method				F = 20.314
	a. Normal	119	70.91	3.76	P = <.000
	b. Cesarean	17	52.15	1.46	Not significant
9.	Residential status				F = 781
	a. Rural	67	69.05	6.97	P <.436
	b. Urban	69	68.09	7.37	Not significant
10.	Duration of illness				**F = 138.16**
	a. Below 3 years	58	71.78	1.25	**P = <.000***
	b. 4 to 7years	26	70.85	2.61	**Significant**
	c. Above 7 years	52	57.12	7.59	
11.	Birth order				
	a. First	26	65.73	9.13	F = 0.204
	b. Second	59	66.54	8.03	P = < .936
	c. Third	19	65.57	9.15	Not
	d. Fourth	15	66.43	8.77	significant
	e. Five and above	17	64.55	9.26	
12.	Food habit				F = 0.722
	a. Vegetarian	8	63.88	9.50	P < .472
	b. Mixed diet	128	66.13	8.50	Not significant

S.No	Demographic variables	f	Mean	SD	One way Annova/ F Test
13.	Sleeping pattern				**F = 3.950**
	a. Below 8hours	87	64.96	8.98	**P < .000***
	b. 8hours	49	70.17	2.82	**Significant**
14.	Supportive system				F = 0.036
	a. Husband	45	66.92	7.99	P < 0.964
	b. Wife	55	66.62	7.84	Not
	c. Children	38	67.06	7.64	Significant

The above table explains that association of psychological and social impacts among demographic and clinical variable for epilepsy clients.

Statistical significance calculated using one way ANNOVA / F Test among this, Age (F=21.681) (P= <.000), Occupation (F= 21.68), (P = <.0001), Education (F = 116.32, P <.000), Family income (F = 21.69, P <.000), Duration of Illness (F=138.16, P= <.000), Sleeping pattern (F=3.950, P<.000) were significantly associated at 0.000 level of significant. Apart from this religion, consanguinity, term at birth, delivery method, residential status, birth order, food habits and supportive system were not significantly associated.

CHAPTER – V

DISCUSSION

CHAPTER - V

DISCUSSION

Based on the objectives of the study and hypotheses, this chapter deals with the detailed discussion of the results of the data interpreted from the statistical analysis. The purpose of the study was to assess the psychological and social impacts of the epilepsy among epileptic clients attending neuro outpatient departments at Government Rajaji Hospital, Madurai.

Epilepsy can have for reaching psychological and social modifications and for some individuals these can be more debilitating than the seizures. Awareness of the psycho social problems which may arise is essential for professionals working with people with epilepsy and their families.

Greater recognition of the wide social and psychological impact of epilepsy is also needed to enable the development and testing of appropriate services and support. A large part of social problems contributes to the over all of therapy's side effect, leads todenial of unemployment, underemployment, social isolation, and psychological distress, affects the quality of life of people with epilepsy.

The study was to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro outpatient department at Government Rajaji Hospital, Madurai. The sampling consists of 136 clients selected by consecutive sample technique. The study was conducted using a standardized interview questionnaire including the socio demographic variables and perceived questionnaire regarding psychological and social impacts. The collected data and distribution of instruction module to reduce the psychological and social impacts. Collected data

were using frequency and percentage distribution, mean, standard deviation and ANNOVA test. The results are discussed based on the objectives.

5.1 Socio demographic variables of epilepsy among epileptic clients attending neuro outpatient department government rajaji hospital madurai.

The present study shows that most of the samples 37 (27.2%) were in the age group 46 and above; 68(50%) were both male and female, most of the samples 119(87.5%) were belongs to Hindu, 63(46.3%) samples were below 8th standard.

Majority of the samples 116 (85.3%) were in daily wages 58 (42.6%) were family income 4000-6000, All of the samples (100%) were married, Most of the Samples 118 (86.8%) were had history of non consanguinity, 118(86.8%) were preterm, 119 (87.5%) were had normal delivery, 69 (50.7%) were residing at urban.

Maximum of the subjects 58 (42.6%) were had below 3years of duration of illness, 55 (42.6%) were had the treatment below 3years, 59 (43.4%) were 2nd birth by birth order, 128 (94.1%) were mixed diet, 87 (64%) were below shows of sleeping pattern (100%) were epilepsy only and (100%) were generalize epilepsy only. Most of the samples 55 (40.4%) were supported by their wife's.

5.2 Findings based on the objectives

The first objective was to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro outpatient department in government Rajaji Hospital, Madurai.

The present study reveals that in seizure worry 4 (2.9%) were had low seizure worry, 106 (77.9%) were had moderate worry, 25 (18.4%) were high level of worry, 1(0.7%) were very high level of seizure worry.

The present study reveals that in overall quality of life 32 (23.5%) were low quality of life, 103 (75.7%) were moderate quality of life, 1(0.7%) were high quality of life.

This study was consistent with the study conducted by **Roshan et al**, in South Korea(2003)revealed that were low quality of life Taisharan university of Malaya Malaysia. 60 subjects were selected by using simple random technique. Another study was consistent with the study conducted in UK. 204 respondents participated by using purposive random sampling. The findings revealed that 36% were have reduced quality of life.

The study reveals that emotional well being1(0.7%) were very low, 22(16.2%) were low emotional well being, 113(83.1%) were moderate emotional well being,

This study explain that fatigue 23 (16.6%) were low fatigue, 112 (82.4%) were had moderate fatigue, 1(0.7%) had high fatigue.

This study reveals that cognitive functions, 2 (1.5%) were very low, 35(25.7%) were low, 99 (72.8%) were moderate cognitive function.

This study reveals that medication effects 3 (2.2%) low effects 130(95.6%) were moderate effects, 3 (2.2%) were high effects.

The present study was reveal about social function 5(3.7%) were low, 129(94.9%) were moderate, 2 (1.5%) were high social functions.

The study also consisted with the study conducted by Melikan, Garakht.et.al, (2012) assessed the clinical factors influencing the health related quality of life of 208 adult clients with epilepsy at Russia. Subjects were selected by purposive sampling technique. Standardized tool quality of life 31 was used to collect the data.They concluded seizure worry (frequency) was associated with all health related quality of life. ($P<0.005$)

It was also supported by an observational prospective study conducted by **Scacho Ivancz.et.al (2010**). 262 subjects were diagnosed with epilepsy at neurology outpatient department BasrahEraq. They concluded seizure severity correlated with emotional well being with quality of life in epilepsy. (P< 0.001)

The second objective was to compare the psychological and social impacts of epilepsy among male and female epileptic clients attending neuro outpatient department at government Rajaji Hospital, Madurai.

When we compare in seizures worryin males 2(1.47%) had low impact of seizure worry, 52(38.24%) had moderate worry and 14 (10.29%) here had high impact of seizure worry and 1(0.74%) had very high impact of seizure worry in female 2(1.47%) were had low seizure worry, 54(39.71%) were had moderate seizure worry, 11 (8.09%) were had high seizure worry.

The mean score of male and female was 56.20 and 61.95 respectively, SD 6.22 and 5.58 respectively. The mean differences were 5.65,'t' value which was significant at P <0.000 level of significant and indicated that there is different between male and female of social and psychological impacts.

When we compare in overall quality of life, in males 16(11.76%) were had low quality of life, 52(38.24%) were had moderate quality of life, 1(0.74%) have high quality of life. In female 16 (11.76%) were had low quality of life, 52 (38.24%) were had moderate quality of life.

The mean score of the male and female was 47.46% and 44.08 respectively, SD was 4.10, 4.20 respectively. The mean differences was3.38 't' value 4.742P <.000 level of significant and indicated that there is different between male and female of psychological and social impacts.

When we compare in **emotional well being**in males 13(9.56%) were had low emotional well being, 55(40.44%) were had high emotional well being. In female 1(0.74%) had very low emotional well beings, 9(6.62%) were had low, and 58 (42.65%) were had high emotional well being.

The mean score of the male and female was 46.23, and 55.70and the SD of male and female was 3.54 and 1.21 respectively. The mean difference was 9.47 ‘t’ value 20.82 P <0.000 level of significant and indicated that is different between male and female of psychological and social impacts.

When we are fatigue**,** in males 13(9.56%) were had low fatigue, 55(40.44%) were had moderate fatigue. In female 10(7.35%) were had low fatigue, 57 (41.91%) were had and 1 (0.74%) had high fatigue.

The mean score of the male and female was 47.94, 65.64 and the SD of male and female was 4.40 and 1.66 respectively. The mean difference was 17.71‘t’ value 31.02P <0.000 level of of significant and indicated that there is a different between male and female of psychological and social impacts.

When we compare with cognitive functionin male 1(0.74%) were had very low cognitive function, 15(11.03%) were had low cognitive function, and 52(38.24%) were had moderate cognitive function. In female 1 (0.74%) had very low cognitive function, 20(14.71%) were had low cognitive function, 47 (34.56%) were had moderate cognitive function impacts.

The mean score of the male and female was 58.21 M 43.14, and the SD was male and female 3.84 and 7.07 were respectively. The mean difference was 15.07, ‘t’ value 15.44 P< 0.000level of significant and indicate that there is different between male and female of psychological and social impacts.

When we compare with in medication effectsin males 1(0.74%) had low worry, 65 (47.29%) were had moderate worry, and 2(1.47%) were had high worry. In female 2(1.47%) were had low worry, 65 (47.79%) were had moderate worry, and 1(0.74%) had high worry.

The mean score of the male and female was 69.54, 55.02 and SD of 6.31, 3.99 was respectively. The mean differences was 14.52, 't' value which was significant at p <0.000 level of significant and indicate that there is different between male and female of psychological and social impacts.

When we compare in social function**,** in males 5(3.68%) were had very low social function, 4(2.94%) were had low social function, 59 (43.38%) were had moderate social function. In female, 4(2.94%) were had very low social function, 2(1.47%) were had low social function, 62(45.58%) were moderate social function.

The mean score of the male and female was 54.91, 49.29 and the SD-8.93, 5.03 respectively. The mean differences was 5.62% 't' value which was significance at p < 0.000 level of significant and indicates that there is different between male and female of social and physiological impacts.

When we compare in their overall scorein male 68(50%) were had moderate score. In female 1(0.74%) had low score. In female 1(0.74%) had low score, 67 (49.26%) were had moderate scores.

The mean score of the male and female was 52.74, 48.74 and the SD was 3.76, 2.88 respectively. The mean differences was 3.99 't' value 6.89 significance at p <0.000 level of significant and indicate that there is different between male and female of social and psychological impacts.

The study was consistent with the study conducted by **LiyuePerminyu Dehao.et.al (2011)**at Taisharan, Malaysia. A comparative study to assess the

determinants of Quality of life in people with epilepsy. 156 subjects were selected by simple random sampling technique. Standardized tool quality of life 89 was used to collect the data. The study revealed that anti epileptic drugs had a greater influence on quality of life in women than in men.

This study also consistent with the study conducted Sachin**Padma Bhatiya (2008)** at Balgerian. A Comparative study to assess the psychological and social impact of epilepsy in women between 15 to 40 years. 100 women and 100 men with epilepsy were selected by simple random sampling technique. Standardized tool quality of life tool 31 scale was used to collect the data. The study revealed that most of the women were affected the impact than men.

Hence the stated Hypothesis - H_1 there is a significant difference in psychological and social impacts of epilepsy between male and female client attending neuro Out Patients Department was accepted.

The third objective was to associate the psychological and social impacts of epilepsy among epileptic clients with their selected socio demographic variables.

Statistical significance calculated using one way ANNOVA/ F Test, Age, (F= 21.681) (P= < 0.000), Occupation (F = 21.68) (P= <.001), Education F = 116.32, P <.000, Family income (F=21.69) (P<.000) Duration of illness (F = 138.16), P = <.000), Sleeping pattern (F = 3.950), (P<.000) were significantly associated with 0.05 level of significant of psychological and social impacts of epilepsy clients Apart from this religion, consanguinity, term at birth, mode of delivery, residential status, birth order, food habits and supportive system were not significantly associated.

The study was supported by a study conducted by **Labedeva et al (2012)** at South Korea. Descriptive study was conducted 202 subjects were selected by

purposive sampling technique. Standardized quality of life tool 31 scale was used to collect the data. They concluded that age was one of the influencing factor by cognitive function, social function, medication effect and total quality of life. ($P<0.05$).

This study was also consistent by a comparative study conducted by Shaqirul Al-asadi (2012) in Bangaladesh. Simple random technique was used to select the sample. 116 samples were selected. Standardized tool was used to collect the data. The study revealed that monthly family income is influenced by unemployment, unmarried and poor to moderate quality of life at ($P<0.0001$) level of significant.

This study was also supported by a correlation and coefficient study conducted by **Renoto.et al (2012)** at University of Zirich Switcher land. 204 samples were selected by purposive sampling technique and Standardized quality of life tool 48 scale was used to collect the data. This study concluded that anti epileptic drug was limit the performance in occupation which affects the income of the family.

Hence the stated Hypothesis - H_2 There is a significant association between psychological and social impacts of epilepsy with their selected socio demographic variables was accepted.

CHAPTER VI

SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENTATIONS

CHAPTER - VI

SUMMARY, CONCLUSION, IMPLICATIONS, RECOMMENDATION

This chapter deals with the summary of the study and conclusions drawn. It also clarifies the implications for different areas like nursing practice. Nursing education, nursing approach, Nursing administrations and recommendations for the further research.

6.1 Summary of the study

Since ancient times, persons who have had chronic or recurrent convulsive disorders, epilepsy have been treated with varying degree of respect and score. Today people with epilepsy still confront superstition, insensitivity and discriminations.

However depending upon the cause type and severity of seizures, the social impact of seizures, and side effects of antiepileptic medications. Some may face some challenges with learning and behaviors and require extra help. The burden of epilepsy may be due to the physical hazards of epilepsy resulting from the predictability of seizures. The social exclusion as a result of negative attitude of others toward people with epilepsy, and the stigma, as children with epilepsy may be barred from marriage, and employment is often derived, even when seizures would not render the work unsuitable or unsafe.

Another major impact and adults is the interpersonal relationship embracing friendship, courtship and marriage, withdrawal from social lives fear of rejection and worry over inheritance and pregnancy limit their social support network and establishment of new family support system in the long run.

A high number of patients with epilepsy have depressive illness and psychosis. They also have higher rate of suicidal attempts or ideation. They also have negative social skills and impaired coping mechanisms.

So the investigator conducted a study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro outpatient department at government Rajaji Hospital, Madurai.

The objectives of the study were

- To assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patients department at Government Rajaji Hospital, Madurai.
- To compare the psychological and social impacts of the epilepsy among male and female epileptic clients attending neuro outpatient department at Government Rajaji Hospital, Madurai.
- To associate the psychological and social impacts of epilepsy among epileptic clients with their selected socio demographic variables.
- To distribute the instructional module to reduce the psychological and social impacts of epilepsy among epileptic clients.

Hypotheses

H_1: There is a significant difference on psychological and social impacts of epilepsy between male and female client attending neuro Out Patients department.

H_2: There is a significant association between psychological and social impacts of epilepsy with their selected socio demographic variables.

The setting of the study was epileptic outpatient department, Government Rajaji Hospital, Madurai. The research approach used in the study was quantitative approach and design was univarant descriptive design. Sampling technique was non probability - consecutive sampling technique. The total sample was 136. Interviewed by method used to collect data based on the objectives of the study.

The content validity and reliability was obtained prior from the study. Subsequently a pilot study was conducted and it found that, the tool was feasible and practicable. A modified Ida Jean orlando's professional response theory (1961) was formulated which provided a useful means in assessing the psychological and social impacts of the epilepsy among epileptic clients.

The data was done for a period of four weeks from 01.08.2015 to 07.09.2015. After getting informed consent from clients, on the day 1st the data was collected by interview method. On 38th day assessed for psychological and social impacts on epilepsy among epileptic clients. The data were analyzed by descriptive and inferential statistics.

Based on their **age** 27(19.9%) subjects belongs in the age group of 15-25years, 36(26.5%) were in the age group of 26-35years and 36-45years respectively, 37 (27.2%) were in the age group of 46 and above.

With respect of **Gender** 68% of the samples were both male and female.

Based on **religion,** 119(87.5%) samples belong to Hindu, 5(3.7%), samples were Christian and 12(8.8%) samples were Muslim.

In the view of **education** 63(46.3%) samples had below 8thstd and 42 samples were (30.9%)9thstd to 10thstd, 20 samples were (14.7%)11thstd to 12thstd and11(8.1%) samples were Degree.

Based on **occupation,** 116 (85.3%) samples were daily wages, 10(7.4%) samples were working in private company, 10(7.4%) were Government employees.

Regarding **family income** per month47 (34.6%) were below Rs.4000, 58(42.6%) were Rs.4000 - Rs.6000, 22 (16.2%) samples were Rs.6000-Rs.9000, 9(6.6%) were above Rs.9000 respectively.

In respect of **marital status** all clients got married.

With regard of **consanguinity** 19(14%) samples were had the family history of consanguinity, 117(86%) samples had the family history of Non-consanguinity.

With the view in **term at birth,** 118(86.8%) were preterm, 8(5.7%) were normal term, 10(7.4%) were post term.

In **Method of delivery**, 119 (87.5%) were normal delivery, 17 (12.5%) were under went cesarean section.

In the aspect of **residential status** 67(49.3%) samples were residing at rural and 69(50.7%) samples were residing at urban.

In the view of **duration of illness,** 58(42.6%) samples were below 3years, 26(19.1%) samples were 4-7years, and 52(38.2%) samples were above 7years respectively.

Based on **duration of treatment** 58(42.6%) samples were below 3years, 26(19.1%) samples were 4-7years, 52(38.2%) samples were above 7years respectively.

In the view of **birth order** 26(19.1%) samples were 1st birth, 59(43.4%) were 2nd birth, 19(14%) were 3rd birth, 15(11%) were 4th birth, 17(12.5%) were five and above.

Based on their **food habits** the study explains 8 (5.9%) samples were vegetarian, 128(94.1%) were mixed diet respectively.

With the view of **sleeping pattern** 87(64%) samples were below 8hours of sleeping and 49(36%) were sleeping 8 hours per day.

Based on **comorbidities** 136(100%) samples were generalized epilepsy only.

In the view of **type of seizures** 136(100%) samples were generalized epilepsy.

In the regard of **supportive system** 45(33.1%) samples were supported by their husbands, 55 (40.4%) samples were supported by their wife's, 36(26.5%) were supported by their children respectively.

With respect of **seizures worry** in males 2(1.47%) had low impact of seizure worry, 52(38.24%) had moderate worry and 13 (9.56%) here had high impact of seizure worry and 1(0.74%) had very high impact of seizure worry in female 2(1.47%) were had low seizure worry, 54(39.71%) were had moderate seizure worry, 11 (8.09%) were had high seizure worry.

With the respects of **overall quality of life**, in males 18(13.24%) were had low quality of life, 49(36.03%) were had moderate quality of life, 1(0.74%) have high quality of life. In female 16 (11.76%) were had low quality of life, 52 (38.24%) were had moderate quality of life.

With the view of **emotional well being** in males 13(9.56%) were had low emotional well being, 55(40.44%) were had high emotional well being. In female 1(0.74%) had very low emotional well beings, 9(6.62%) were had low, and 58 (42.65%) were had high emotional well being.

With the regards of **fatigue,** in males 13(9.56%) were had low fatigue, 55(40.44%) were had moderate fatigue. In female 10(7.35%) were had low fatigue, 57 (41.91%) were had and 1 (0.74%) had high fatigue.

When compare with **cognitive function** in male 1(0.74%) were had very low cognitive function, 15(11.03%) were had low cognitive function, and 52(38.24%)

were had moderate cognitive function. In female 1 (0.74%) had very low cognitive function, 20(14.71%) were had low cognitive function, 47 (34.56%) were had moderate cognitive function impacts.

When the worry of **medication effects** in males 1(0.74%) had low worry, 65 (47.29%) were had moderate worry, and 2(1.47%) were had high worry. In female 2(1.47%) were had low worry, 65 (47.79%) were had moderate worry, and 1(0.74%) had high worry.

With the view of **social function,** in males 5(3.68%) were had very low social function, 4(2.94%) were had low social function, 59 (43.38%) were had moderate social function. In female, 4(2.94%) were had very low social function, 2(1.47%) were had low social function, 62(45.58%) were moderate social function.

With the respects of **overall score** in male 68(50%) were had moderate score. In female 1(0.74%) had low score, 67 (49.26%) were had moderate scores.

The above table explained about psychological and social impacts of **seizure worry** of epilepsy clients.56.30, 61.95, 6.22, 5.58 respectively mean difference was 5.65. The test of significance was calculated using 't' value is 5.67 at P <.000 level of significance.

The table explained about **overall quality of life** of epilepsy clients. The mean and standard deviation of male and female was 47.46, 44.08, 4.10, and 4.20 respectively. The mean difference was 3.38. The test was significance was calculated using 't' value is 4.74 at P <.000 level of significance.

The table explains psychological and social impacts of **emotional well being** of the epilepsy clients. The mean and standard deviation of male and female was 46.23, 55.70, 3.54 and 1.21 respectively. The mean difference was 9.48. The test of significance was calculated using 't' value is 20.82 at P <.000 level of significance.

The table explains psychological and social impacts of **fatigue** of the epilepsy clients. The mean and standard deviation of male and female was 47.94, 65.64, 4.40 and 1.66 were respectively. The mean difference was 17.71.The test of significant calculated using 't' value is 31.02 at P < .000 level of significance.

This table explains psychological and social impacts of **cognitive functioning** of the epilepsy clients. The mean and SD of male and female was 58.21, 43.14,3.84 and 7.07 respectively. The mean difference was 15.07. The test of significance was calculated using 't' value is 15.44 at P<.000 level of significance.

The table explains psychological and social impacts of **medication effects** of the epilepsy clients. The mean and SD of male and female was 69.54, 55.02, 6.31 and 3.99 respectively. The mean difference was 14.51. The test of significance was calculated using 't' value is 16.03 at P<.000 which level of significance.

The table explains psychological and social impacts of **social functions** of the epilepsy clients. The mean and SD of male and female was 54.91, 49.29, 8.93 and 5.03 respectively. The mean difference was 5.62. The test was significance was calculated using 't' value is 6.12 at P<.000 which level of significance.

This table explains psychological and social impacts of **overall total score** of epilepsy clients. The mean and SD of male and female was 52.74, 48.78,3.76 and 2.88 respectively. The mean difference was 3.97. The test of significance was calculated using 't' value is 6.89 at P<.000 level of significance.

Statistical significance calculated using one way ANNOVA / F Test among this, Age (F=21.681) (P= <.000), Occupation (F= 21.68), (P = <.0001), Education (F = 116.32, P <.000), Family income (F = 21.69, P <.000), Duration of Illness (F=138.16, P= <.000), Sleeping pattern (F=3.950, P<.000) were significantly associated at 0.000 level. Apart from this religion, consanguinity, term at birth, mode

of delivery, residential status, birth order, food habits, and support system were not significantly associated.

With respect of **seizures worry** in males 2(1.47%) had low impact of seizure worry, 52(38.24%) had moderate worry and 14 (10.29%) here had high impact of seizure worry and 1(0.74%) had very high impact of seizure worry in female 2(1.47%) were had low seizure worry, 54(39.71%) were had moderate seizure worry, 11 (8.09%) were had high seizure worry.

With the respects of **overall quality of life**, in males 16(11.76%) were had low quality of life, 52(38.24%) were had moderate quality of life, 1(0.74%) have high quality of life. In female 16 (11.76%) were had low quality of life, 52 (38.24%) were had moderate quality of life.

With the view of **emotional well being** in males 13(9.56%) were had low emotional well being, 55(40.44%) were had high emotional well being. In female 1(0.74%) had very low emotional well beings, 9(6.62%) were had low, and 58 (42.65%) were had high emotional well being.

With the regards of **fatigue,** in males 13(9.56%) were had low fatigue, 55(40.44%) were had moderate fatigue. In female 10(7.35%) were had low fatigue, 57 (41.91%) were had and 1 (0.74%) had high fatigue.

When compare with **cognitive function** in male 1(0.74%) were had very low cognitive function, 15(11.03%) were had low cognitive function, and 52(38.24%) were had moderate cognitive function. In female 1 (0.74%) had very low cognitive function, 20(14.71%) were had low cognitive function, 47 (34.56%) were had moderate cognitive function impacts.

When the worry of **medication effects** in males 1(0.74%) had low worry, 65 (47.29%) were had moderate worry, and 2(1.47%) were had high worry. In female

2(1.47%) were had low worry, 65 (47.79%) were had moderate worry, and 1(0.74%) had high worry.

With the view of **social function,** in males 5(3.68%) were had very low social function, 4(2.94%) were had low social function, 59 (43.38%) were had moderate social function. In female, 4(2.94%) were had very low social function, 2(1.47%) were had low social function, 62(45.58%) were moderate social function.

With the respects of **overall score** in male 68(50%) were had moderate score. In female 1(0.74%) had low score. In female 1(0.74%) had low score, 67 (49.26%) were had moderate scores.

6.2 Conclusion

The study findings statistically proved that most of the epileptic clients attending neuro outpatient department at Government Rajaji Hospital were had moderate psychological and social impacts of epilepsy. Also there was difference in male and female with their psychological and social impacts. There was association of psychological and social impacts with age, family income, occupation, education, duration of illness and sleeping pattern. As age increases, the activities and day to day performances will decrease. This leads to increase in psychological and social impacts of quality of life. If family income is reduced, they cannot fulfill their basic needs which affect the quality of life. Epileptic clients won't get job due to denial. This leads to increase psychological and social impacts of quality of life. And also their education gets affected due to the chronic duration of illness, which increases the psychological and social impacts of quality of life. Due to the impaired sleep disturbance their day to day performances affected. This increases the psychological and social impacts of quality of life. Hence the researcher concluded that the

instructional module needs to be distributed, to reduce the psychological and social impacts of epilepsy among epileptic clients.

6.3 Implications of the study

The study has implications in nursing practice, Nursing education, Nursing Research and Nursing administrations.

6.3.1 Nursing Practice

- Different methods of teaching can be used to reduce impact and improve the knowledge like vocational rehabilitation, continuous behavior therapy, memory enhancement etc.
- Curriculum should be based on improve the knowledge to cope up with psychological and social impacts.
- The community health nurse can plan teaching programme like Mass educations.

6.3.2 Nursing Education

- As nursing education, we must strengthen the non pharmacological methods of managing epilepsy and should be incorporate in nursing subjects.
- Nursing Education should emphasize on preparing nurses to various treatment modalities and update their knowledge in all fields.
- The study will enhance the nursing students to acquire knowledge to eliminate social stigma among epileptic client and cope up with the epilepsy in a positive manner.

6.3.3 Nursing Research

- This study can be baseline for future studies to build upon and motivate the investigator for further studies.
- An experimental study can also conducted with large samples.
- Nurse should conduct periodic research and disseminate the findings through publications, conferences and seminars.
- As nursing profession focused on evidence based practice, the nursing personal should involve in research activities to come out with successful remedies to reduce the burden of the impact.

6.3.4 Nursing Administrations

- As nurse administrator, we must take initiation in formulating policies on various aspects of care.
- Nursing administrator should or have various staff development programmes to educate the nurses on importance to reduce the psychological and social impacts of epilepsy among epileptic clients.
- Nursing administrator should motivate the nurses to gain knowledge to reduce the psychological and social impacts of epilepsy among epileptic clients.

6.4 Recommendations

The study recommends the following further research

- The study can conduct with large samples to generalize the findings.
- Comparative studies can be conducted between various types of epileptic clients.
- The study is conducted in different settings like community.

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APPENDICES

APPENDIX - I

Letter seeking and granting permission to conduct the study

From

Mrs.S.Sobarani
I year M.Sc (N),
College of Nursing,
Madurai Medical College,
Madurai.

To

The Medical Superintendent
Government Rajaji Hospital,
Madurai.

Through proper channel
Respected sir,

Sub: M.Sc (N) dissertation approval of proposal request -reg.

As per curriculum recommended by the Indian Nursing Council and Tamilnadu Dr.MGR Medical University all the M.Sc (N) students are required to conduct a dissertation study for the partial fulfillment of the course.

I have selected a study on **"A study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patient Department, Government Rajaji Hospital, Madurai".**

With this Reference No.12332/E1/5/2014 dt: 27.01.2015 from ethical committee.

So, kindly I request you to consider, guide and allow me conduct the Pilot study

Madurai

26.05.2015

yours sincerely,

S. Sobarani

(S.SOBARANI)

Forwarded
S. Rajeswari
26/5/15
For Principal
COLLEGE OF NURSING
Madurai Medical College
Madurai-20.

Permitted
MEDICAL SUPERINTENDENT
Govt. Rajaji Hospital,
MADURAI.

From

Mrs.S.Sobarani
I year M.Sc (N),
College of Nursing,
Madurai Medical College,
Madurai.

To

The Head of the Department,
Neuro Medicine,
Government Rajaji Hospital,
Madurai.

Through proper channel
Respected sir,

Sub: M.Sc (N) dissertation approval of proposal request -reg.

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So, kindly I request you to consider, guide and allow me conduct the Pilot study

Madurai

26.05.2015

yours sincerely,

S Sobarani

(S.SOBARANI)

Forwarded
S. Rajamani
26/5/15
For Principal
COLLEGE OF NURSING
Madurai Medical College
Madurai-20.

Permitted
28/5/15
THE PROFESSOR & HOD
Dept. of Neurology
Govt. Rajaji Hospital /
Madurai Medical College
Madurai

From

Mrs.S.Sobarani
I year M.Sc (N),
College of Nursing,
Madurai Medical College,
Madurai.

To

The Medical Superintendent
Government Rajaji Hospital,
Madurai.

Through proper channel
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Sub: M.Sc (N) dissertation approval of proposal request -reg.

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yours sincerely,

S Sobarani

(S.SOBARANI)

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26/5/15
For Principal
COLLEGE OF NURSING
Madurai Medical College
Madurai-20.

Permitted
MEDICAL SUPERINTENDENT
Govt. Rajaji Hospital,
MADURAI.

From

Mrs.S.Sobarani
I year M.Sc (N),
College of Nursing,
Madurai Medical College,
Madurai.

To

The Head of the Department,
Neuro Medicine,
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Madurai.

Through proper channel
Respected sir,

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As per curriculum recommended by the Indian Nursing Council and Tamilnadu Dr.MGR Medical University all the M.Sc (N) students are required to conduct a dissertation study for the partial fulfillment of the course.

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So, kindly I request you to consider, guide and allow me conduct the study.

Madurai

26.05.2015

yours sincerely,

S Sobarani

(S.SOBARANI)

Forwarded
S. Rajamani
26/5/15
For Principal
COLLEGE OF NURSING
Madurai Medical College
Madurai-20.

Permitted

THE PROFESSOR & HOD
Dept. of Neurology
Govt. Rajaji Hospital /
Madurai Medical College
Madurai

APPENDIX - II

Ethical committee approval letter

Ref.No.12332/E1/5/2014

Madurai Medical College,
Maduai -20. Dated: 27.01.2015

Institutional Review Board/Independent Ethics Committee
Dean, Madurai Medical College &
Government Rajaji Hospital, Madurai 625 020 . Convenor
Capt.Dr.B.Santhakumar,MD (FM). deanmdu@gmail.com

Sub: Establishment – Madurai Medical College, Madurai-20 –
Ethics Committee Meeting – Meeting Minutes - for December 2014 –
Approved copy – reg.

The Ethics Committee meeting of the Madurai Medical College, Madurai was held on January 05th 2015 at 10.00 Am to 12.00 Noon at Anaesthesia Seminar Hall at Govt. Rajaji Hospital, Madurai . The following members of the Ethics Committee have attended the meeting.

1.Dr.V.Nagarajan,M.D.,D.M(Neuro) Ph: 0452-2629629 Cell No.9843052029 nag9999@gmail.com.	Professor of Neurology (Retired) D.No.72, Vakkil New Street, Simmakkal, Madurai -1	Chairman
2.Dr.Mohan Prasad, MS.M.Ch. Cell.No.9843050822 (Oncology) drbkcmp@gmail.com	Professor & H.O.D of Surgical Oncology (Retired) D.No.32, West Avani Moola Street, Madurai.-1	Member Secretary
3. Dr.L.Santhanalakshmi, MD (Physiology) Cell No.9842593412 dr.l.santhanalakshmi@gmail.com.	Vice Principal, Prof. & H.O.D. Institute of Physiology Madurai Medical College	Member
4.Dr.K.Parameswari, MD(Pharmacology) Cell No.9994026056 drparameswari@yahoo.com.	Director of Pharmacology Madurai Medical College.	Member
5.Dr.S.Vadivel Murugan, MD., (Gen.Medicine) Cell No.9566543048 svadivelmurugan_2007@rediffmail.com.	Professor & H.O.D of Medicine Madurai Medical College	Member
6.Dr.A.Sankaramahalingam, MS., (Gen. Surgery) Cell.No.9443367312 chandrahospitalmdu@gmail.com	Professor & H.O.D. Surgery Madurai Medical College.	Member
7.Mrs.Mercy Immaculate Rubalatha, M.A., Med., Cell.No.9367792650 lathadevadoss86@gmail.com	50/5, Corporation Officer's Quarters, Gandhi Museum Road, Thamukam, Madurai-20.	Member
8.Thiru.Pala.Ramasamy, B.A.,B.L., Cell.No.9842165127 palaramasamy2011@gmail.com	Advocate, D.No.72,Palam Station Road, Sellur, Madurai-20.	Member
9.Thiru.P.K.M.Chelliah, B.A., Cell No.9894349599 pkmandco@gmail.com	Businessman, 21 Jawahar Street, Gandhi Nagar, Madurai-20.	Member

The following Project was approved by the Ethical Committee

Name of P.G.	Course	Name of the Project	Remarks
Mrs. S.Sobarani Sobaranimahendran66@gmail.com	M.Sc (Nursing)1st year Community Health Nursing, Madurai Medical College, Madurai.	A study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patient Department, Govt.Rajaji Hospital, Madurai.	Approved

Please note that the investigator should adhere the following: She/He should get a detailed informed consent from the patients/participants and maintain it Confidentially.

1. She/He should carry out the work without detrimental to regular activities as well as without extra expenditure to the institution or to Government.
2. She/He should inform the institution Ethical Committee, in case of any change of study procedure, site and investigation or guide.
3. She/He should not deviate the area of the work for which applied for Ethical clearance. She/He should inform the IEC immediately, in case of any adverse events or Serious adverse reactions.
4. She/He should abide to the rules and regulations of the institution.
5. She/He should complete the work within the specific period and if any Extension of time is required He/She should apply for permission again and do the work.
6. She/He should submit the summary of the work to the Ethical Committee on Completion of the work.
7. She/He should not claim any funds from the institution while doing the work or on completion.
8. She/He should understand that the members of IEC have the right to monitor the work with prior intimation.

Member Secretary
Ethical Committee

Chairman
Ethical Committee

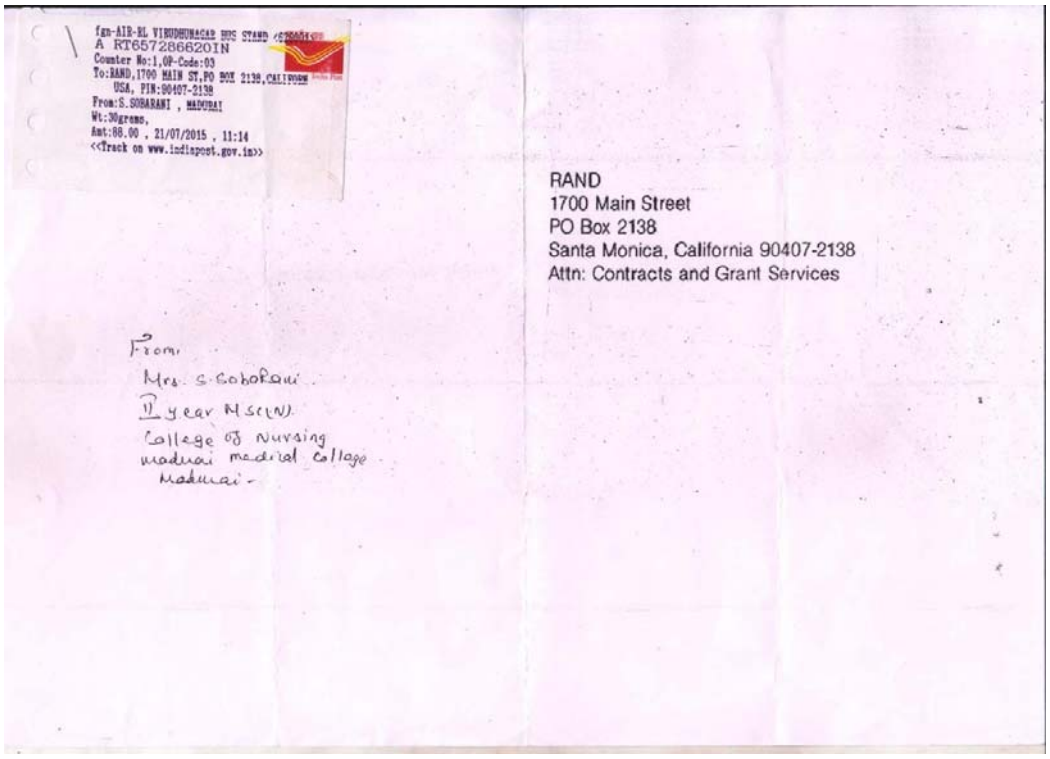
27.1.15

DEAN/Convenor
Madurai Medical College &
Govt. Rajaji Hospital, Madurai.

To
The above Applicant
-thro. Head of the Department concerned

APPENDIX – III

Tool Permission Letter



fgn-AIR-RL VIRUDHUNAGAR HDO STAMP
A RT657286620IN
Counter No:1,OP-Code:03
To:RAND,1700 MAIN ST,PO BOX 2138,CALIFORN
USA, PIN:90407-2138
From:S.SUBARANI , MADURAI
Wt:30grams,
Amt:88.00 , 21/07/2015 , 11:14
<<Track on www.indiapost.gov.in>>

RAND
1700 Main Street
PO Box 2138
Santa Monica, California 90407-2138
Attn: Contracts and Grant Services

From,
Mrs. S. Subarani.
II year M.Sc(N).
College of Nursing
madurai medical college
Madurai.

APPENDIX – IV

Content validity certificate

CONTENT VALIDITY CERTIFICATE

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Quality of Life in Epilepsy 31

Prepared for data collection by Mrs.S.Sobarani. II year M.Sc (N) student, College of Nursing, Madurai Medical College, Madurai, who has undertaken the study field on thesis entitled **"A study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patient Department, Govt.Rajaji Hospital, Madurai"** has been validated by me.

M Sweeni 3/7/15

SIGNATURE OF THE EXPERT

NAME:

DESIGNATION: ASSOCIATE PROFESSOR Institute Of Community Medicine Madurai Medical College Madurai

ADDRESS:

DATE:

CONTENT VALIDITY CERTIFICATE

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Quality of Life in Epilepsy 31

Prepared for data collection by Mrs.S.Sobarani. II year M.Sc (N) student, College of Nursing, Madurai Medical College, Madurai, who has undertaken the study field on thesis entitled **"A study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patient Department, Government Rajaji Hospital, Madurai"** has been validated by me.

SIGNATURE OF THE EXPERT

THE PROFESSOR & HOD
Dept. of Neurology
Govt. Rajaji Hospital /
Madurai Medical College
Madurai

NAME:

DESIGNATION:

ADDRESS:

DATE:

CONTENT VALIDITY CERTIFICATE

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SECTION A- Demographic Data

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Mr. Y. John Sam Arun Prabu,
M.Sc.,(N)M.Sc.,(Psy),PGDHM
PhD, Community Health Nursing
CSI Jeyaraj Annapackiam
College of Nursing
Pasumalai, Madurai-625 004

SIGNATURE OF THE EXPERT

NAME: DR. Y. John Sam Arun Prabu.

DESIGNATION: Professor.

ADDRESS: CSI JACON

DATE: 04/8/15.

CONTENT VALIDITY CERTIFICATE

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Quality of Life in Epilepsy 31

Prepared for data collection by Mrs.S.Sobarani. II year M.Sc (N) student, College of Nursing, Madurai Medical College, Madurai, who has undertaken the study field on thesis entitled **"A study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patient Department, Government Rajaji Hospital, Madurai"** has been validated by me.

SIGNATURE OF THE EXPERT

NAME:

DESIGNATION: Professor in Community Health Nursing

ADDRESS:

DATE: 4/9/15

CONTENT VALIDITY CERTIFICATE

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Quality of Life in Epilepsy 31

Prepared for data collection by Mrs.S.Sobarani. II year M.Sc (N) student, College of Nursing, Madurai Medical College, Madurai, who has undertaken the study field on thesis entitled **"A study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patient Department, Government Rajaji Hospital, Madurai"** has been validated by me.

P. Subbalakshmi

SIGNATURE OF THE EXPERT

NAME: P. SUBBALAKSHMI

DESIGNATION: Professor

ADDRESS: Sri. K.R.N. CoN

DATE: 21/7/15

APPENDIX- V

Informed consent form

ஒப்புதல் அறிக்கை

ஆராய்ச்சிதலைப்பு : வலிப்புநோயாளிகளின் மனசார்ந்த மற்றும்

சமூகவிளைவுகள் பற்றிய ஆய்வு

நாள் :

எனது பெயர் _____ இந்த ஆய்வினில் பங்கேற்க நான் சம்மதிக்கிறேன். எனக்கு இந்த செவிலிய ஆய்வினைப் பற்றிய முழு விவரம் விளக்கமாக எடுத்துரைக்கப்பட்டது. இந்த ஆய்வில் பங்கு கொள்வதில் உள்ள நன்மைகுலூ மற்றும் தீமைகள் பற்றி முழுமையாக புரிந்துகொண்டேன். மேலும் எனது நாள் இந்த ஆய்விலிருந்து எந்த சமயத்திலும் விலகிக்கொள்ள முழு அனுமதி வழங்கப்பட்டுள்ளது. என்னுடைய பெயர் மற்றும் விவரங்கள் ரகசியமாக வைத்து கொள்ளப்படும் என்றும் எனக்கு உறுதி அளிக்கப்பட்டுள்ளது.

இப்படிக்கு

(நோயாளியின் கையொப்பம்)

APPENDIX – VI

Research Tool – English

SOCIO DEMOGRAPHIC VARIABLES

1. Age in completed years ☐
    1. 15-25years
    2. 26-35years
    3. 36-45years
    4. 46-50 years

2. Gender ☐
    1. Male
    2. Female

3. Religion ☐
    1. Hindu
    2. Christian
    3. Muslim
    4. Others

4. Education ☐
    1. Upto 8th std
    2. Upto 10th std
    3. Upto 12th std
    4. Degree

5. Occupation ☐
    1. Cooly
    2. Private work
    3. Government
    4. Unemployed
    5. Vocational

6. Monthly family income ☐
    1. <Rs.4000
    2. Rs.4001 - Rs.6000
    3. Rs.6001 - Rs.9000
    4. >Rs.9000

7. Marital status ☐
    1. Married
    2. Unmarried
    3. Separated / Widower
    4. Divorced

8. Consanguinity ☐
    1. Consanguineous
    2. Non-consanguineous

9. Term at birth ☐
    1. Full term
    2. Pre term
    3. Post term

10. Delivery method ☐
    1. Normal delivery
    2. Cesarean section
    3. Instrumental delivery

11. Residential Place ☐
    1. Rural
    2. Urban

12. Duration of illness ☐
    1. 1 - 4 years
    2. 5 - 9 years
    3. 10 - 14 years
    4. More than 15 years

13. Duration of treatments ☐
    1. 1 - 4 years
    2. 5 - 9 years
    3. 10 - 14 years
    4. More than 15 years

14. Birth order ☐
    1. First
    2. Second
    3. Third
    4. Fourth
    5. Five and more

15. Food habit ☐
    1. Vegetarian
    2. Non vegetarian
    3. Mixed diet

16. Sleeping pattern ☐
    1. < 8 hours
    2. 8hours
    3. > 8hours

17. Epilepsy with Comorbidities ☐
    1. Epilepsy alone
    2. Mental retardation with epilepsy
    3. Cerebral palsy with epilepsy
    4. Post traumatic condition with epilepsy

18. Types of seizures ☐
    1. Generalized
    2. Grand mal
    3. Tonic clonic
    4. Meningitis
    5. Others

19. Supportive system ☐
    1. Husband
    2. Wife
    3. Children
    4. Parents and siblings

COLLEGE OF NURSING,

MADURAI MEDICAL COLLEGE,

MADURAI.

PSYCHOLOGICAL AND SOCIAL IMPACTS OF EPILEPSY

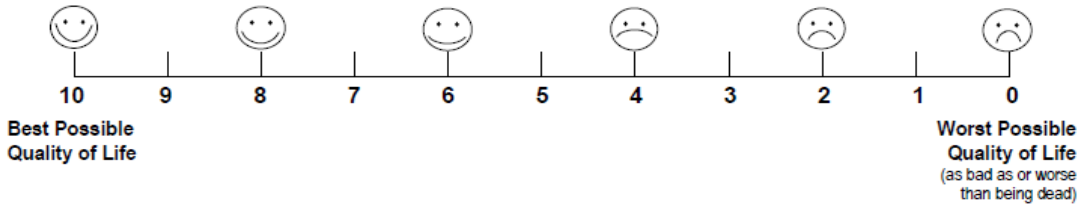
INSTRUCTIONS:-

This questionnaire should be completed only by the person who has epilepsy (not a relative or friend) because no one else knows how YOU feel.

Answer every question by circling the appropriate number (1, 2, 3...).

1. Overall, how would you rate your quality of life?

(Circle one number on the scale below)



SOCIAL IMPACTS ON FEELINGS REGARDING

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
2.	Did you feel full of pep?	1	2	3	4	5	6
3.	Did you have a lot of energy?	1	2	3	4	5	6
4.	Did you feel worm out?	1	2	3	4	5	6
5.	Did you feel tired?	1	2	3	4	5	6

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
6.	Have you been a very nervous system?	1	2	3	4	5	6
7.	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
8.	Have you felt cam and peaceful?	1	2	3	4	5	6
9.	Have you felt downhearted and blue?	1	2	3	4	5	6
10.	Have you been a happy person?	1	2	3	4	5	6

EMOTION REGARDING

		Not at all	Some what	Moderately	A lot	Very much
11.	How much do the above problems and worries about emotions distress you overall?	1	2	3	4	5

REGARDING DAILY SOCIAL ACTIVITIES

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
12.	Has your health limited your social activities (such as visiting with friends or close relatives)?	1	2	3	4	5	6

REGARDING ANTIEPILEPTIC MEDICATION HAS CAUSED TROUBLE WITH LEISURE ACTIVITIES

		A great Deal	A lot	Some what	Only a little	Not at all
13.	Leisure activities (such as hobbies, going out)	1	2	3	4	5
14.	Driving (or transportation)	1	2	3	4	5
		Not at all bother some				Extremely bothersom
15.	How much do your work limitations bother you?	1	2	3	4	5
16.	How much do your social limitations bother you?	1	2	3	4	5
17.	How much do physical effects of antiepileptic medication bother you?	1	2	3	4	5
18.	How much do mental effects of antiepileptic medication bother you?	1	2	3	4	5
		Not at all	Some what	Moderat ely	A lot	Very much
19.	How much do the above problems and worries about daily activities distress you overall?	1	2	3	4	5

REGARDING THINKING, MEMORY, READING, CONCENTRATING

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
20.	Did you have difficulty reasoning and solving problems (such as making plans, making decisions, learning new	1	2	3	4	5	6

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
	things)						

		Yes, a great deal	Yes, Some what	Only A little	No , Not at all
21.	Did you have you had any trouble with your memory?	1	2	3	4

REGARDING MARITAL LIFE

		Yes, a great deal	Yes, Some what	Only A little	No , Not at all
22.	Did you have satisfaction with your married life?	1	2	3	4
23.	Did you have sexual relationship with your spouse?	1	2	3	4

REGARDING VOCATIONAL IMPACTS

		Yes, a great deal	Yes, Some what	Only A little	No , Not at all
24.	Did you have job satisfaction with your job?	1	2	3	4
25.	Did you have monthly income satisfaction with your job?	1	2	3	4

REGARDING SEIZURES

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
26.	Did you have worried about having another seizure?	1	2	3	4	5	6
					Worry a lot	Occasionally worry	Don't worry at all
27.	Do you worry about hurting yourself during a seizure?				1	2	3

REGARDING OVER ALL QUALITY

		Not at all	Some what	Moderately	A lot	Very much
28.	How much the problem and worries about mental function?	1	2	3	4	5
		Very well	Pretty good	Good & bad parts about equal	Pretty bad	Very bad could hardly be worse
29.	How will you feel the total quality of life?	1	2	3	4	5

		Not at all	Some what	Moderately	A lot	Very much
		Worse health state				Best health state
30.	How good or bad health do you think?	20	40	60	80	100

APPENDIX – VII

Research Tool – Tamil

தன்னிலைவிபரக்குறிப்பு

கீழ்க்கண்டவற்றைகவனமாகபடித்துபொருத்தமானவற்றை டிக் (✓) குறியிடவும்.

1. கடந்தவயது ☐

   அ. 15- 25வயது

   ஆ. 26 - 35வயது

   இ. 36-45வயது

   ஈ. 46-50வயது

2. பாலினம் ☐

   அ. ஆண்

   ஆ. பெண்

3. மதம் ☐

   அ. இந்து

   ஆ. கிறிஸ்தவர்

   இ. முஸ்லீம்

   ஈ. பிறமதத்தவர்

4. கல்வித்தகுதி ☐

   அ. மரபுசாராகல்விமுறை

   ஆ. நடுநிலைக்கல்வி

   இ. மேல்நிலைக்கல்வி

   ஈ. பட்டப்படிப்பு

5. தொழில் ☐

   அ. கூலிவேலை

   ஆ. தனியார் வேலை

   இ. அரசாங்கவேலை

   ஈ. வேலையில்லாதவர்

6. குடும்பமாதவருமானம் ☐

அ. ரூ.4000க்குகுறைவாக

ஆ. ரூ.4001 முதல் ரூ.6000 வரை

இ. ரூ.6001 முதல் ரூ.9000 வரை

ஈ. ரூ.9000க்கும் மேல்

7. திருமணத்தகுதி ☐

அ. திருமணமானவர்

ஆ. திருமணமாகாதவர்

இ. பிரிந்துவாழ்பவர் / விதவை

ஈ. விவாகரத்தானவர்

8. இரத்தசம்பந்தப்பட்டதிருமணமா? ☐

அ. ஆம்

ஆ. இல்லை

9. பிரசவமானமுறை ☐

அ. சுகப்பிரசவம்

ஆ. அறுவைசிகிச்சை மூலம்

இ. ஆயுதப் பிரசவம்

11. வசிப்பிடம் ☐

அ. கிராமம்

ஆ. நகரம்

12. நோயின் காலஅளவு ☐

அ. 1 வருடம் முதல் 3 வருடங்கள்

ஆ. 4 வருடங்கள் முதல் 7 வருடங்கள்

இ. 7 வருடங்கள் முதல் 9 வருடங்கள்

ஈ. 10 வருடங்களுக்குமேல்

13. நோயின் சிகிச்சைக்குஎடுத்துக்கொண்டகாலஅளவு ☐

அ. 1 வருடம் முதல் 3 வருடங்கள்

ஆ. 4 வருடங்கள் முதல் 7 வருடங்கள்

இ. 7 வருடங்கள் முதல் 9 வருடங்கள்

ஈ. 10 வருடங்களுக்குமேல்

14. பிறப்புவரிசை ☐

அ. முதல் குழந்தை

ஆ. இரண்டாவதுகுழந்தை

இ. மூன்றாவதுகுழந்தை

ஈ. நான்காவதுகுழந்தை

உ. ஐந்துமற்றும் அதற்குமேல்

15. உணவுப்பழக்கவழக்கம் ☐

அ. சைவம்

ஆ. அசைவம்

இ. இரண்டும் கலந்தது

16. உறக்கமுறை ☐

அ. 8மணிநேரத்திற்கும் குறைவான

ஆ. 8மணிநேரம்

இ. 8மணிநேரத்திற்கும் அதிகமான

17. வலிப்பும் அதுசார்ந்தநோய்களும் ☐

அ. வலிப்புமட்டும்

ஆ. வலிப்பும், மூளை வளர்ச்சிகுன்றியும்

இ. வலிப்பும்,பெருமூளைவாதமும்

ஈ. வலிப்பும்,தலைக்காயமும்

18. வலிப்பின் வகைகள் □

அ. பொதுவானவலிப்பு

ஆ. காக்காவலிப்பு

இ. மூளை நோய் வலிப்பு

ஈ. மற்றவை

19. யாரைசார்ந்துவாழ்பவர் □

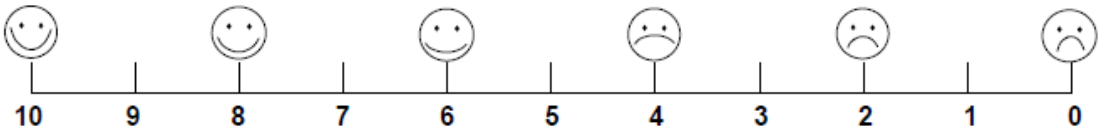
அ. கணவரை

ஆ. மனைவியை

இ. குழந்தைகளை

ஈ. பெற்றோர் மற்றும் உடன்பிறந்தோரை

உங்களுடைய வாழ்க்கைதரம் எப்படி என்று குறிப்பிடுவீர்கள்?



வாழ்க்கைத்தரம் நன்றாக உள்ளது

வாழ்க்கைத்தரம் மோசமாகஉள்ளது

	எல்லாநேரங்களிலும்	பலநேரங்களில்	நல்லபாதிப்புக்குட்படும் போது	சிலநேரங்களில்	வெகுசிலநேரங்களில்	ஒருபோதும்
	1	2	3	4	5	6
1. உங்களுக்குவலிப்புவந்தவுடன் முழுமையான ஆற்றல் உள்ளவர்களாகஉணர்கிறீர்களா?						
2. வலிப்புநோய் வந்த பின் அதிகசக்தியுடன் இருப்பதை உணர்கிறீர்களா?						
3. நீங்கள் சக்தியை இழந்துவிட்டதாகஉணர்கிறீர்களா?						
4. நீங்கள் சோர்வுடன் இருப்பதாகஉணர்கிறீர்களா?						
5. நீங்கள் நரம்புதளர்ச்சிஅதிகமாகஉடையவரா?						
6. உங்களுக்குமனம் எளிதில் உடைந்ததுபோல் உணர்கிறீர்களா?						
7. நீங்கள் அமைதியாகவும்,சமாதானத்துடனும் இருப்பதாகஉணர்கிறீர்களா?						
8. எந்த சூழ்நிலையிலாவதுநாம் மகிழ்ச்சிஉடன் இருக்க இயலாதுஎன்றுஉணர்ந்ததுஉண்டா?						
9. எந்தஅளவிற்குமனக்கவலைகள் உங்களைபின்னடையசெய்கிறது?						
10. எந்தஅளவில் பிரச்சனைகளும்,கவலையும் உங்களிடம் உள்ளசக்தியைகுறைத்துஉங்களைபின்வாங்க வைத்துள்ளது?						

வாழ்க்கைத்தரம் எப்படிஉள்ளது	மிகவும் பாதிக்கப்பட்டுள்ளது	அதிகமாகஉள்ளது	மிதமாகஉள்ளது	சிலநேரங்களில்	ஒருபோதும் இல்லை
	1	2	3	4	5
11.நீங்கள் சந்தோஷமானமனிதராக இருந்ததுண்டா?					
12.எந்தளவிற்குமனக்கவலைகள் உங்களைபின்னடையசெய்தது?					
13.உங்களுடையஉடல்நலம் உங்களதுசமூகபழக்கத்திற்குதடைசெய்ததுண்டா?					
14.உங்களுடையபொழுதுபோக்குஅளவைகுறிப்பிடவும்.					
15.உங்களதுபயணம் செய்யும் அளவைகுறிப்பிடவும்.					
16.எந்தளவிற்குவேலைசெய்ய இயலாமைஉங்களைபாதித்ததுகுறிப்பிடவும்.					
17.சமூகபழக்கத்தடைஎந்தளவில் உங்களைபாதித்ததுகுறிப்பிடவும்					
18.பிரச்சனைகளும்,கவலைகளும் தினசரிநடவடிக்கைள் குறித்துஎழுந்துஉங்களைகவலைக்குஉள்ளாக்கியதா? குறிப்பிடவும்.					
19.திட்டமிடல் திறனும்,முடிவெடுக்கும் திறனும் எந்தளவிற்குகுறைபாடாகஉள்ளதுஎன்பதைகுறிப்பிடவும்					
20.கடந்தநான்குவாரங்களில் உங்களதுஞாபகசக்தியால் ஏதாவதுபாதிப்பு இருக்கிறதாஎன்பதைகுறிப்பிடவும்.					
21.உங்களதுஞாபககுறைபாடுகுறித்துயாராவது கூறியதுண்டா					
22.வாசிக்கும் போதுகவனம் குறைந்ததுண்டாஎன்பதைகுறிப்பிடவும்.					
23.வேலைசெய்யும் போதுகவனகுறைபாடு இருந்ததுண்டா? குறிப்பிடவும்.					

	ஆம்,உள்ளது	ஆம்,சிலநேரங்களில்	இல்லை,ஒருசிலமே நாங்களில்	ஒருபோதும் இல்லை	
	1	2	3	4	
24.உங்களதுமணவாழ்க்கைதிருப்தியாகஉள்ளதா ? குறிப்பிடவும்.					
25.உங்களுடையதாம்பத்யவாழ்க்கைதிருப்தியாக உள்ளதா?					
26.உங்களுடையவேலையில் திருப்திஉள்ளதா?					
27.உங்களுடையமாதவருமானம் போதுமானதாகஉள்ளதா?					
28.நீங்கள் அடுத்தவலிப்பைபற்றிகவலைபட்டதுண்டா?					

	எல்லாநேரங்களிலும்	பலநேரங்களில்	நல்லபாதிப்புக்குட	சிலநேரங்களில்	வெகுசிலநேரங்கள்	ஒருபோதும் இல்லை
	1	2	3	4	5	6
29.வலிப்புவரும் போதுநீங்கள் நீங்களாகவேஉங்களைகாயப்படுத்திகொண்டதை தநினைத்துவருந்தியதுஉண்டா?						

	ஒருபோதும் இல்லை	சிலநேரங்களில்	மிதமாகஉள்ளது	அதிகமாகஉள்ளது	மிகவும் அழுத்தமாகஉள்ளது.	
	1	2	3	4	5	
30.உங்களுக்குபிரச்சனைகளும்,மருந்துகளும் எந்தஅளவிற்குஉங்களுக்குமனநலம் பாதிப்புக்குள்ளாகி இருக்கிறது?						

APPENDIX- VIII

Certificate for English editing

TO WHOMSOVER IT MAY CONCERN

This is to certify that the dissertation **"A study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patient Department, Government Rajaji Hospital, Madurai"** done by Mrs.S.SobaRani,M.Sc., Nursing II year student, college of Nursing, Madurai Medical College, Madurai-20 has been edited for English language appropriateness.

Name :

Signature

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APPENDIX - IX

Certificate for Tamil editing

TO WHOMSOVER IT MAY CONCERN

This is to certify that the dissertation **"A study to assess the psychological and social impacts of epilepsy among epileptic clients attending neuro out patient Department, Govt.Rajaji Hospital, Madurai".** Mrs.S.Soba Rani ,M.Sc., Nursing II year student, college of Nursing, Madurai Medical College, Madurai-20 has been edited for Tamil language appropriateness.

Name : Dr.N. Balasubramani/20/8/15 Signature

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Institution: DEPARTMENT OF TAMIL REV. JACOB MEMORIAL CHRISTIAN COLLEGE SANTHIPURAM, AMBILIKAI - 624 612 DINDIGUL-DIST, TAMILNADU

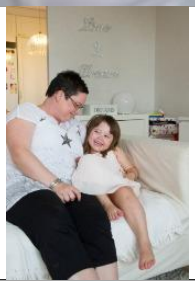
APPENDIX - X

Photographs

APPENDIX – XI

வலிப்பு நோய் குறித்த வழிமுறைகள்

செய்ய வேண்டியவைகள்

	அடையாள அட்டையையும், நோயாளியை பற்றிய தகவலும் அடையாள அட்டையில் இருக்க வேண்டும்.
	மருந்து மாத்திரைகளை தொடர்ச்சியாக சாப்பிட வேண்டும்.
	மருத்துவரின் ஆலோசனையின்படி நடந்து கொள்ள வேண்டும்.
	நன்றாக உறங்க வேண்டும்
	கர்ப்ப காலத்தில் மருத்துவரின் ஆலோசனைப்படி மருந்து உட்கொள்ள வேண்டும்.
	குடும்பத்தாருடைய ஒத்துழைப்பு அவசியம்

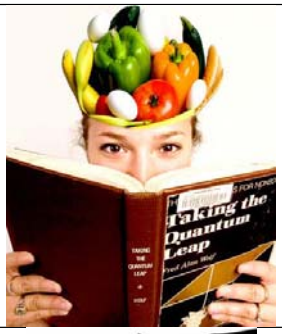
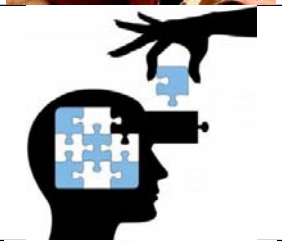
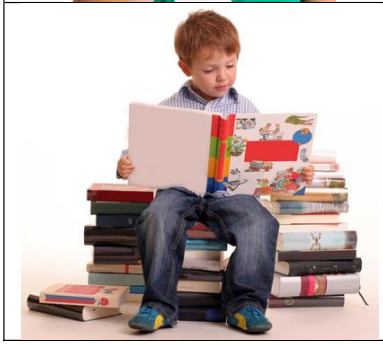
செய்ய கூடாதவைகள்

	நீர் நிலைகள் உள்ள இடங்களுக்கு சென்று நீந்தக்கூடாது.
	வெல்டிங் மற்றும் தீ சம்மந்தமான பணிகளை செய்யக்கூடாது
	மது அருந்தவோ, புகைப் பிடிக்கவோ கூடாது.

வலிப்பு நோயாளிகளின் வேலைவாய்ப்பு சம்மந்தமான வழிமுறைகள்

	தனக்கு தெரிந்த வேலையை வீட்டில் இருந்தபடியே செய்யலாம்
	வேலையை பகிர்ந்து செய்யலாம்

ஞாபக சக்தியை அதிகரித்தல்

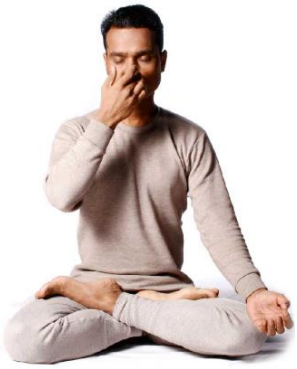
	காய்கறி, பழங்கள் நன்றாக சாப்பிட வேண்டும்.
	அடிக்கடி மூளைக்கு வேலை கொடுத்துக் கொண்டே இருக்க வேண்டும்.
	அடிக்கடி சிந்தித்து கொண்டே இருக்க வேண்டும்.
	அதிகமான புத்தகங்களை படிக்க வேண்டும்.

சுய உதவிக் குழுக்கள்

	பெற்றோர் மற்றும் குடும்பத்தாரின் ஒத்துழைப்பு அன்பு, உதவும் தன்மை மற்றும் கைத்தொழில் கற்றல் ஆகியவைகளை செய்யலாம்.
	நோய் உள்ள குழந்தைகளின் பெற்றோர்கள் இணைந்து குழந்தைகளின் அனுபவங்களையும் மற்றும் குழந்தைகளின் அல்லது வலிப்பு நோய் உள்ளவரின் வளர்ச்சிக்கு உதவலாம். இது அன்பான குடும்ப சூழ்நிலைக்கு ஏதுவாக இருக்கும்.
	தன்னார்வ தொண்டு நிறுவனங்கள் மூலம் ஒவ்வொரு வலிப்பு நோயாளிகளின் கற்பனை திறன் மூலமாக கலைப்பயிற்சி, (வரைதல், உருவாக்குதல்) அதை வெளிப்படுத்துதல், அதன் மூலமாக கற்றுத் தருதல் போன்றவற்றை வளர்க்கலாம்.
	குழந்தைகளுக்கு மருத்துவ உதவித்தொகை பெற்றுத் தரலாம் மற்றும் கல்வி உதவித்தொகையும் பெற்றுத்தரலாம்.
	தன்னுடைய படிப்பு, வேலை மற்றும் சமுதாய வளர்ச்சிக்கு போக்குவரத்துக்கு உதவித் தொகை பெற்றுத்தரலாம்.

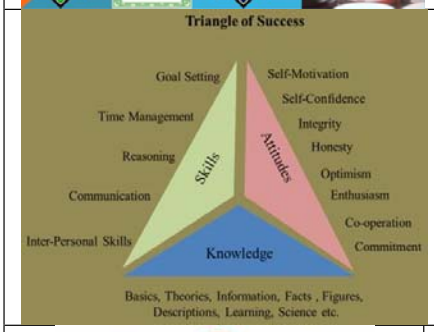
	சுய தொழில் வேலைவாய்ப்பு மற்றும் கலைத் திறன் மற்றும் கற்பனைத்திறனை வெளிப்படுத்தி அதன் மூலம் வருவாய் ஈட்டும் தொழிலை கற்றுக்கொடுக்கலாம்.

அறிவாற்றலை விரிவடைய செய்யும் முறைகள்

	ஆழ் மூச்சு பயிற்சி செய்தல். உடலில் பிரானவாயு திறனை அதிகரித்தல்
	தன்னுடைய கவனம் முழுவதும் வேறு வேலையில் அல்லது வேறு செயல்பாட்டில் செலுத்த வேண்டும்.
	பாட்டு மற்றும் நடனம் போன்ற கலைகளில் தன்னை ஈடுபடுத்திக் கொள்ள வேண்டும்.
	தெய்வ வழிபாடு மிக முக்கியம்
	மற்றவர்களுக்கு உதவி செய்து தன் மன பாரத்தை குறைக்கலாம்

	உறவினருடன் மற்றும் நண்பர்களுடன் அவர்கள் வீட்டிற்கு சென்று நல்லவற்றை பேசலாம், செய்யலாம்.
	பொழுதுபோக்கு அம்சங்களை ஏற்படுத்திக் கொள்ளலாம்.
	படம் வரைந்து மற்றும் வண்ணம் கொடுத்து தன்னுடைய கற்பனை திறனை வளர்த்துக் கொள்ளலாம்.

சமூக உறவுகளை மேம்படுத்துதல்

	சமூக உறவுகளை மேம்படுத்தும் விதமாக உடன் பயிலும் மாணவர்களுடனும், உடன் பணிபுரிபவர்களுடனும் சுமூக உறவை ஏற்படுத்திக் கொள்ளவும்.
	கலாச்சாரம், மொழி, சமுதாயம், இன வேறுபாடு இல்லாமல் சகஜமாக எல்லோரிடமும் பழக வேண்டும்.
	அணுகுமுறைகள், திறமைகள், அறிவு ஆகிய மூன்றும் வெற்றியின் முதல் மூன்று படிகள்.
	அனைவருடனும் சமமாக பழகி, அவர்களிடம் உள்ள திறமைகளையும், அறிவையும் பகிர்ந்து கொண்டு தன்னுடைய அறிவை வளர்த்துக் கொள்ள வேண்டும்.
	நல்லதையே பேச வேண்டும் மற்றும் நல்லதையே செய்ய வேண்டும். மரம் நடுதல் மற்றும் சமூக தொண்டு நிறுவனங்களுடன் இணைந்து செயல்பட வேண்டும்.